State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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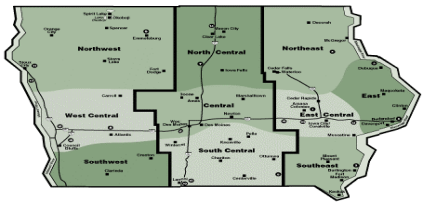
Table of Contents

1.4 Overview of the State



Overview. Key factors that provide context for the state's Maternal and Child Health (MCH) annual report and state plan are highlighted in this overview. This section briefly outlines Iowa's demography, population changes, economic indicators and significant public initiatives. Additionally, major strategic planning efforts affecting development of program activities are identified to provide a backdrop for plan development.

Iowa's Land. Iowa is known throughout the country as the "Hawkeye" state. Most of Iowa is composed of gentle rolling prairies, covered with some of the world's most fertile soil and lies between the high bluffs of Mississippi and Missouri Rivers. Iowa is one of the country's most important and prosperous agriculture sectors and is also known as the breadbasket of the country. The deep black soil yields huge quantities of corn, soybeans, oats, hay, wheat, and barley, which help support its cattle and hogs and supplies the large food processing industry. Manufacturing, especially agribusiness, is a large source of income for Iowans.

Changes in demography. Estimates from the U. S. Census Bureau show that growth in Iowa during the 1990s is confined to two pockets: one in and around Des Moines and the other in the Cedar Rapids-to-Iowa City corridor. Meanwhile, 45-50% of Iowa's 99 counties are expected to continue to lose population. Up to 20% of Iowa's rural counties could lose up to 5% of their 1990 population by 2010. This rural-to-urban shift is seen as a result of families moving to Des Moines and other urban areas.

Employment and Population Changes. Iowa's unemployment rate dropped to its lowest monthly rate for many years in 1999, to 2.5%. The rate has been on a steady decline since the beginning of the decade except for in 1992. The number of unemployed is so low that leaders fear there will not be enough workers available to fill the jobs that will be developed in the coming years. This concern has encouraged employers to seek new employees from other states. This influx of workers has created a need for interpreters and health information in many different languages.

The most notable population change is the increase in Hispanic immigrants. Census estimates show that residents of Hispanic origin increased from 1.2% in 1990 to 2.0% in 1998. This group has shown the largest growth of any minority group in the state, increasing 67% from 1990 to 1998.

The following table shows the significant increases in immigrant clients who are served by the Title V agencies.

Number and Percent of Change of Title V

Maternal Health Center Clients Served

Fiscal Year	Total Number of Clients Served	Number of Hispanic Clients Served
FFY99	4620	566 (8.2%)
FFY98	4577	566 (8.1%)
FFY97	4654	545 (8.5%)
FFY96	4736	516 (9.2%)
FFY95	4734	410 (11.5%)

Source: IDPH Patient Service Record Data System

Even with this influx of new citizens, Iowa's total population is projected to experience only modest growth between now and 2010. While overall population remains stable, the minority populations are expected to grow in both absolute numbers and percentage of total population.

Refugees from east European countries, especially Bosnia, as well as illegal immigrants from other countries have brought more school aged children. From 1993 to 1999, the number of student enrollment of limited English proficient students has increased from 3785 to 9160, which is an annual increase of 12%.

Poverty. The percent of families in Iowa living at or below the federal poverty level has been declining since 1990. Data from 1996-1998 shows the overall average poverty rate for Iowa families is 9.4%. The ratio of women and men in poverty is 1.4 to 1.0, which closely approximates national data.

Welfare Reform. On October 1, 1993, Iowa replaced Aid to Families with Dependent Children (AFDC) with a comprehensive welfare reform program known as the Family Investment Program (FIP). A central element of FIP is the requirement that welfare recipients carry out individual plans for self-sufficiency, called Family Investment Agreements (FIA's). When a FIP household fails to sign or follow the terms of an FIA they are considered to have chosen a Limited Benefit Plan (LBP). The original 1993 LBP consisted of a 12–month period beginning with three months of cash benefits at the same level as FIP, followed by three months of reduced cash benefits, followed by six month of no cash benefits. In February 1996, Iowa implemented revised LBP policies that eliminated the three-month period of level benefits and distinguished between first and subsequent LBP assignments. The first LBP consisted of a 9-month period with three months of reduced cash benefits followed by six months of no cash benefits. A subsequent LBP was simply a 6-month period

of no cash benefits. The LBP was again revised as of June 1, 1999, and will continue to consist of first and subsequent LBP's. In the first LBP there is no period of reduced benefits, no set period of ineligibility and the person who chooses the LBP can reconsider by signing an FIA at any time to stop the LBP. For second and subsequent LBP's chosen by the same person or by either parent in a 2-parent household, there is a 6-month minimum period of ineligibility. When the 6-month period ends, ineligibility continues until the person who chose the LBP reapplies for FIP, reconsiders by signing an FIA and completes 20 hours of work or another approved PROMISE JOBS activity. The FIP child care disregard was eliminated effective July 1, 1999. FIP recipients and other people whose income is considered for FIP are now automatically eligible for state child care assistance without regard to the latter program's eligibility requirements and waiting list.

Since welfare reform began, the total recipients decreased by approximately about 10,000 each year, from 95,000 in 1994 to 65,000 in 1997. Concerns about potentially detrimental effects of the LBP on children spurred policy makers to require that the Iowa Department of Human Services (DHS) systematically monitor the well-being of children in families that enter the LBP. In direct response to these requirements, DHS established the Well-Being Visit Program. DHS and the Iowa Department of Public Health (IDPH) administer this program in conjunction with local public health agencies throughout Iowa's 99 counties. These local agencies employ registered nurses and social workers to conduct the well-being visits. The primary purpose of well-being visits is to support families in their move to being self-supported. A secondary purpose is to check on the well-being of children in the families, including linking children and families with health and human service needs to appropriate community resources. LBP families are now eligible for one well-being visit during the second month of a second or subsequent LBP. Acceptance of a well-being visit is voluntary on the part of the client. Priority is placed on completing a face-to-face visit with the client and the client's children present in their home. If a visit with the children present cannot be scheduled, attempts to schedule visits are made in the following order by visit type: a face-to-face visit with the client and children at an alternate site, a face-to-face visit at home with the client only or an alternate site or a telephone visit. In 1999, 3,069 well-being visits were completed in Iowa. Fifteen percent of the visits were done over the phone, 17% were completed in the home with the child present, 5% were complete in the home without the child present, and about 2% were done at an alternate site. During the well-being visits, 2172 referrals were made for various services. 18% were referred to the food pantry, 15% for heating assistance, 13% for Medicaid Title XIX, and 13% for housing assistance.

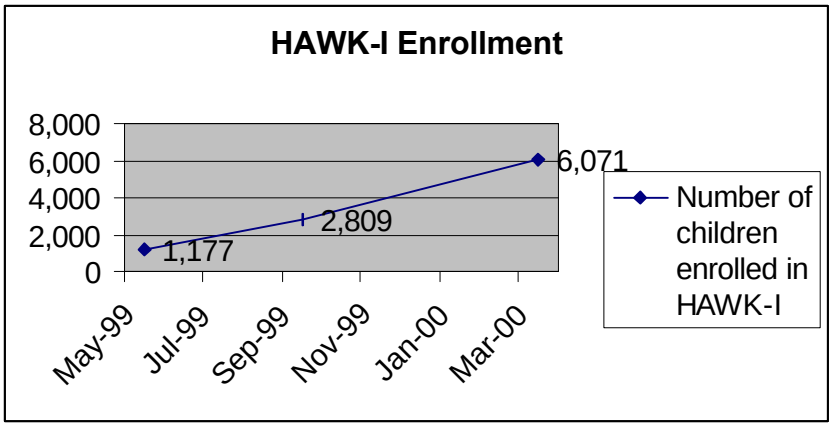
Community Empowerment Areas. Iowa has been progressive in implementing a concept of partnership between local and state levels of government. In 1997, legislation provided for the

establishment of "innovation zones." Several state agencies collaborated with local organizations within approved zones to reduce barriers to services as identified by local communities. During the 1998 General Assembly, legislation was passed, which built upon the prior state efforts of "innovation zones". The purposes of Community Empowerment legislation were to establish local community collaborations, create a partnership between communities and state government, and improve the wellbeing of children 0-5 years of age and their families. An additional emphasis was to empower communities to build a system of services to improve effectiveness of local education, health, and human services programs. Community empowerment areas have been designated to cover all 99 counties. This legislation will directly influence community-based MCH services in Iowa.

Perinatal Guidelines. The 1998 legislature directed the Iowa Department of Public Health (IDPH) to develop and maintain statewide perinatal guidelines. State guidelines were available previously. However, administrative rules were written with input from the public and the Perinatal Advisory Committee. These rules, effective March 17, 1999, allow for voluntary participation by hospital, and define the criteria for perinatal level designation.

State Child Health Insurance Program. The 1998 Iowa Acts, Chapter 1196, authorized health care coverage for specified uninsured children in Iowa based on the federal initiative of State Childrens' Health Insurance Programs (SCHIP). Legislation created a SCHIP plan that expanded Medicaid coverage to children whose family incomes were up to 133% of the federal poverty level. Medicaid expansion began for children under the age of nineteen on July 1, 1998. Initial estimates predicted additional 15,500 children would be covered based on this expansion. As of March 2000, 7,895 children have enrolled in the Medicaid expansion.

HAWK-I (Healthy and Well Kids in Iowa) began January 1, 1999. This separate private insurance plan provides health insurance coverage to children with a family income between 133% and 185% of the poverty level. Federal estimates indicated Iowa had potentially 40,000 children eligible for HAWK-I. Reports from March 2000 indicate 6,071 children have enrolled in HAWK-I since January 1, 1999. Iowa's initial amendment to the Children's Health Insurance Program was approved by the federal government in mid-June, 1999.



Dr. Jeffrey Lobas, Director of Child Health Specialty Clinics, and Dr. Edward Schor, Medical Director of the Family and Community Health Division/Iowa Department of Public Health, are members of the Clinical Advisory Committee for the HAWK-I Board. Dr. Lobas also is the Chair of the Subcommittee for Children with Special Health Care Needs. The subcommittee addresses health coverage issues faced by children with special health care needs and their families. Both subcommittees made recommendations to the HAWK-I Board during January and February 2000. As of this writing, the board has yet to act on the recommendations submitted by the subcommittees.

In July 1999, the Family Service Bureau, became a Robert Wood Johnson Foundation grantee for Iowa's Covering Kids Project, an initiative that increases access to health care for low-income children. The goals of the project are to: 1) design and conduct outreach programs in pilot communities to help identify and enroll children into Medicaid or HAWK-I; 2) simplify the enrollment process; and 3) coordinate existing coverage programs for low-income children.

IDPH Strategic Plan Summary

After completing an internal and external assessment in 1998, the IDPH developed the ***Iowa Department of Public Health's 2000-2005 Strategic Plan.*** This document resulted from several stages of review, analysis and planning that actively involved over 100 staff members and members from the department's contractors, boards, and commissions. The *Strategic Plan* outlines goals in four areas: the Public Health System, Internal Government, Image and Communication, and Health Status. The Strategic Planning Team also developed strategies, outcomes, and measures for each goal. The goals include:

- Use existing and evolving technology and standards for the delivery of public health services and information.
- Improve the capacity of local board of health and other public health partners to address public health needs and implement the core public health functions.
- Understand and respond to the needs and health concerns of all Iowans.
- Eliminate health disparities
- Improve access to services for underserved populations, especially those who remain at increased risk of illness and premature death.

Children with Special Health Care Needs. The Child Health Specialty Clinics (CHSC) is Iowa's Special Needs Program supported by Title V funds (See Organizational Structure 1.5.1.1). This program is based at the University of Iowa. CHSC supports 13 regional centers throughout the state which provide and manage a number of programs, including subspecialty clinics, care coordination services, technical assistance activities and planning and evaluation functions for programs for children with special health care needs. Additionally, CHSC works closely with the state MCH Director to implement and develop programs to serve Iowa's children.

The process for developing priorities continues to be that of the use of focus groups including staff, community leaders, parents, and advisory councils at the CHSC regional centers. There were at least two statewide meetings for regional coordinators and directors of programs where discussions regarding priorities occurred. Management staff utilized a SWOT analysis in developing a strategic direction for CHSC. There have also been regular planning meetings with the Department of Human Services regarding children with special health care needs and regular meetings with the Department of Public Health and Department of Education defining the needs of this population.

A number of important issues have been identified through this process. The area of child and adolescent mental health programs continues to be one of the biggest concerns within the state, and a number of initiatives and groups have met regarding possible solutions. Quality of care for CHSCN enrolled in managed care continues to be a concern. The Subcommittee to the HAWK-I Board for Children with Special Health Care Needs made recommendations to the board and state legislature and continues to develop details regarding these through the year.

1.5 The State Title V Agency

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

The Iowa legislature has designated the Iowa Department of Public Health (IDPH), a cabinet level agency, as the administrator for Title V and MCH services. The legislature also directs IDPH to contract with the University of Iowa Department of Pediatrics, Child Health Specialty Clinics (CHSC) as the state's Title V services for children with special health care needs (CSHCN) program. Statutory authority is identified in the Code of Iowa Chapter 135. Iowa Administrative Code 641, Chapter 76, provides further reference for the purpose and scope of Iowa's program. Legislative authorization for state expenditure of federal funding under the federal block grant is identified in House File 737 of the 1999 Session of the Iowa General Assembly. Contracts between IDPH and CHSC outline the responsibilities of both agencies for fulfilling the mandate for maternal and child health services. Copies of the contracts are available upon request. Additional State of Iowa statutes that relate to MCH and CSHCN programs are listed in Appendix A.

The Division of Family and Community Health (FCH) includes the Family Services Bureau (FSB), the primary MCH unit within the state. The accompanying tables of organization (Appendix B) illustrate the relationship of the division and the bureau to IDPH. Within the FCH, major responsibility for administration of the MCH Block Grant lies with the FSB. The bureau also administers a portion of the state's Title X Family Planning services. The organizational structure within IDPH relative to FSB has remained stable in recent years. However, outside FSB the new director of IDPH was appointed in May of 1999. The Department is implementing further changes as of July 1, 2000, with the additional of two divisions, Environmental Health and Tobacco, to the three current divisions, Family and Community Health, Substance Abuse and Health Promotion, and Administration and Regulatory Affairs.

Responsibility for coordinating the program for CSHCN is an administrative responsibility of the FCH division and is under contract to the University of Iowa, Department of Pediatrics. Within the University of Iowa, CHSC has responsibility for administration of the contract. A table of organization for CHSC is located in Appendix B.

1.5.1.2 Program Capacity

As identified in Organizational Structure 1.5.1.1, program activities for Iowa's Title V program are carried out by the IDPH, Family and Community Health Division, Family Services Bureau, the University of Iowa, and Child Health Specialty Clinics. These two entities subcontract extensively with local community-based public health and primary care providers. A list of subcontractors is located in Appendix C, E and P. IDPH's Dental and WIC/Nutrition Bureaus also assume responsibility for selected program activities.

Family Services Bureau. Core public health functions directed toward the health of mothers and children are centered within IDPH's FSB. Areas of work include system planning, development and evaluation; developing and monitoring standards of care; contract management; and coordinating health-related services between and among agencies serving mothers and children. Staff work to develop state level infrastructure and local, community based capacity. The majority of bureau functions are accomplished within the Women's Health Team, and the Child and Adolescent Health Team. Activities within each team include coordination with DHS and the Iowa Department of Education (IDE); integrating WIC/Nutrition and Dental Health services; collaborating with Iowa's Regents Universities; working with private and public organizations and service providers; and representing IDPH on issues of concern to childbearing families. FSB program staff, along with personnel from the Dental and WIC/Nutrition Bureaus, provide training, staff development, and technical assistance to contract agencies, public health nursing, and other groups as requested.

F&CH Division Integration (FSB, WIC/Nutrition, Dental Health, Community Services, and Primary Care & Rural Health). The forthcoming fiscal year (FFY2001) represents the first year of the combined grant application for a five-year project period. IDPH provides community-based public health agencies services through contracts to local agencies. As in years past, the FSB continues to collaborate with the Dental Health Bureau, and the WIC/Nutrition Bureau in preparing a joint MCH, WIC, and Family Planning grant application guidance. This collaboration extends to the grant review process, utilizing a team approach. The combined effort produced an application that is based on community needs assessments and establishes a foundation for supporting core public health functions in local agencies. The single application contributes to the transition from a primary care oriented model to an essential public health services model for local agencies.

In response to State Representative Wayne Ford's concern about African American infant mortality and the desire of the Iowa Department of Public Health to enter into dialogue with representation from the minority population, in January 2000 Iowa convened the Minority Health Advisory Task Force. The Task Force was given the charge to provide recommendations in various areas pertaining to health care access and service delivery. To ensure that input was provided by minorities regarding their perceived issues and health concerns, membership for the taskforce was recruited from the African American, Latino, Asian Pacific Islander, Native Americans, refugee, and immigrant populations. Development of short and long term recommendations ranging from one to five years were an additional directive to the task force. Janice Edmunds-Wells, SWS, of the FSB serves as IDPH's minority health liaison.

PREGNANT WOMEN, MOTHERS, AND INFANTS

Women's Health Team. The Women's Health Team is comprised of FSB professionals who have extensive experience working with women of childbearing age. The Women's Health Team provides direction, oversight, and monitoring for the 26 local community-based maternal health agencies. The agencies provide services in all of Iowa's 99 counties (see map located in Appendix C). Systems development activities are coordinated with the IDPH Family Planning Program, Family Planning Council of Iowa, hospitals, schools, adolescent health programs, and statewide women's health initiatives. The maternal health Community Health Consultant coordinates activities with two Healthy Start Projects managed by Northern Plains and Visiting Nurse Services of Des Moines. Issues discussed by the group in the past year included standards of care and development of a position statement regarding women's health issues. Technical support is provided to local maternal health agencies, family planning agencies, the IDPH Women's Health Team, and Healthy Iowans 2010. The IDPH initiates and monitors contracts with the University of Iowa Hospitals and Clinics (UIHC), Departments of OB/GYN and Pediatrics. The Women's Health Team works closely with the University of Iowa in program development and has primary oversight responsibility for maintaining IDPH's Title V and state funded perinatal contracts. Title V sponsored contracts with the University include the Statewide Perinatal Program, the Barriers to Prenatal Care Survey Project, and the recently funded Repetitive Prematurity Prevention Project.

Maternal Health Centers. Twenty-six community-based maternal health projects provide services to all 99 counties. Community based maternal health clinics provide prenatal and postpartum care to low income women. Services include health and nutrition education; risk assessment and psychosocial screening; referral, care coordination, presumptive eligibility for Title XIX, arrangements for medical prenatal care and dental assessments; and assistance with plans for delivery and postpartum visits. In addition, five agencies provide direct medical care services. Outreach efforts include community based strategies for hard to reach populations, with special emphasis on plans for informing residents of available services. Collaboration with health care providers focuses on development of a system of medical care to meet local needs.

The purpose of Maternal and Child Health (MCH) programs is to promote the development of local systems of health care for children ages 0 to 21, pregnant women and their families. Fundamental to MCH programs are services that are family-centered, community-based, collaborative, comprehensive, flexible, coordinated, culturally competent, and developmentally appropriate. MCH programs shall promote the core public health functions of assessment, policy development, and assurance. Child Health centers are discussed further in the next section (page 16).

FSB staff, in collaboration with contracted MCH center staff, have developed a Quality Assurance Matrix that encompasses the Performance Standards, National and State Performance Measures, and the Activities of the MCH pyramid. This matrix will be utilized to coordinate state and local quality assurance activities.

Maternal health centers are charged with designing health programs and services that are responsive to the needs in the communities. Performance standards have been developed by FSB for the purpose of ensuring a baseline level of quality maternal health service throughout the state of Iowa. (see Appendix D) The goals of the MCH Performance Standards are

- to ensure the delivery of quality, community-based, family-centered maternal and child health services throughout Iowa;
- to support the systematic evaluation of maternal and child health services and contract agency competency;
- to design effective mechanisms for the identification, assessment, resolution, and evaluation of maternal and child health service delivery issues;
- to define and communicate the performance standards of the Family Services Bureau to MCH contract agencies, consumers, community health care providers, and other community program administrators;
- to provide mechanisms through which community MCH personnel become knowledgeable about and participate in performance standards activities; and
- to ensure promotion of preventive health services to maternal and child health consumers, and availability of such services within the community.

Request for Proposals (RFP) were issued for a five year period to groups interested in providing public health services at the community level for Child Health, Maternal Health, Family Planning, and WIC. The Department will select applicants that demonstrated the maximum ability to meet the following criteria:

- Access: An existing and continuing commitment to reach and serve the targeted populations in Iowa.
- Management: A capacity and a willingness to provide for responsible management of resources and to establish all necessary control systems to safeguard funds and resources.
- Quality: A commitment to provide quality services with sensitivity to and awareness of client satisfaction.
- Coordination: An ability to effectively coordinate services for women, children, and families.
- Cost: An ability to meet the program requirements while maximizing available resources.

Modes of delivery of the medical components of prenatal care include traditional clinic settings; purchase of services from private practitioners; and agreements with local hospitals. For those women whose family income is less than 185% of poverty and are not eligible for Title XIX, the maternal health centers may authorize payment for the following procedures: dental treatment, ultrasound, non-stress tests, Rhogam, maternal serum alphafetoprotein screening, diagnostic procedures, and obstetrical consultation. Maternal health staff members are responsible for determining eligibility for the OB Indigent Care Program. This state-funded program pays for deliveries for women whose income is between 185% and 300% of poverty and who meet additional criteria.

Nutrition Services. The Bureau of Nutrition and WIC coordinates the nutrition components of MCH projects, providing staff assistance for the state and local MCH programs, family planning, adolescent health, dental health programs, the perinatal team, and CHSC. A major focus of this bureau is integration of the statewide WIC supplemental nutrition program with MCH services at the local level. Training, consultation, and educational programs are provided for all MCH programs. The FSB works with the Bureau of Nutrition and WIC and other professional health organizations to develop and implement breastfeeding promotion initiatives.

The Iowa Lactation Task Force, a statewide coalition, includes private sector and public health professions who provide technical assistance to WIC, MCH, family planning, public health nursing/visiting nurse agencies, and private health care providers. *Quality Times,* a publication of the IDPH WIC Program, is designed to support communication among 20 community-based breastfeeding coalitions in Iowa and provide them with research and resource information to support their efforts. In addition, the Iowa Lactation Task Force has developed a breastfeeding guide, *Breastfeeding in the 1st Week*: *A Counseling Guide for Health Care Professionals*. The *Quality Times* also provides communication among breastfeeding advocates in Iowa.

Statewide Perinatal Care Program. The statewide Perinatal Care Program provides professional training, development of standards/guidelines of care, consultation to regional and primary providers, and evaluation of the quality of care delivered. Through a contract with the University of Iowa Hospitals and Clinics (UIHC), these services are provided to all hospitals that perform deliveries. More intensive services are directed toward three tertiary care centers (including UIHC) and fifteen secondary care centers.

Infant Mortality Prevention Center. The Infant Mortality Prevention Center was formed in 1993 in response to national data that showed an unacceptably high infant mortality rate in the city

of Des Moines, Iowa. Currently, the center consists of a Polk County division, now housed within the Visiting Nurse Service/Healthy Start Project, and a statewide division, housed at the Iowa Department of Public Health. Visiting Nurse Services is the Title V agency for Polk County. The center provides a locus for developing new infant mortality prevention strategies and a resource for implementing, on a statewide basis, the Iowa Child Death Review Team recommendations.

The medical director for the Polk County project also serves as the medical consultant for the statewide project and works in conjunction with the epidemiologist who also is the director of the Iowa SIDS Alliance.

The Polk County Center continues to be the epicenter of the organization where new strategies are piloted. Activities of the center include the following:

- bringing together organizations that have concerns for infant health, resulting in greater knowledge and coordination of services and increased awareness of areas that impact the outcomes of pregnancy and the ability of parents to care for their infants;
- implementation of the "back to sleep" educational campaign to reduce the incidence of infants dying of SIDS;
- development of an infant mortality telephone reporting system to allow for use of infant death reporting data; and
- development of statewide autopsy and death scene protocols for sudden and unexpected deaths in infancy.

CHILDREN

Child and Adolescent Health Team. The Child and Adolescent Health Team is comprised of FSB professional staff with expertise in child and adolescent health issues. The team provides direction and oversight to 26 local community based child health centers covering all 99 counties (see map located in Appendix E). Improved access to health care, brought about by expanded Medicaid eligibility guidelines and the growth of managed care programs, has resulted in community-based efforts to identify medical homes for children receiving Title V services. State staff members provide technical support for feasibility studies and planned change.

Other program activities include cooperative efforts with Early Access, Part C, Medicaid Administrative Claiming, Dental Bureau, Environmental Bureau, School Based Youth Services Program (SBYSP) administered by Iowa Department of Education, newborn hearing screening, child care consultation, and Early Periodic, Screening, Diagnosis and Treatment (EPSDT). Issues addressed by the Child Adolescent Health Team included the children's health insurance program,

development of FSB Performance Standards, development of the comprehensive Maternal and Child Health data base, development of the Family Service Quality Assurance Plan, and legislative issues. Technical support is provided by the team to the immunization program, the lead screening program, injury prevention projects, child welfare initiatives, WIC, and children's health insurance.

Child Health Centers.

Through contracts with IDPH child health centers are charged with developing health programs and designing services that are responsive to the needs of the community. The MCH Performance Standards described previously are utilized to ensure a baseline level of quality child health service throughout the state of Iowa. (See Appendix D)

The focus of the child health centers in the past year has been to broaden activities related to population based services and infrastructure building in the community. Contract agencies are working with managed care organizations to build partnerships to improve care coordination services at the local level. Other activities of local agencies include: assurance of a medical home, informing families about services available in the community and from Medicaid and HAWK-I (CHIP), outreach activities for uninsured children, and working with the dental community to improve dental access. In addition these agencies serve as resources for other community providers by assisting clients to obtain dental treatment, lead screening and follow-up, transportation, and developing linkages with other community resources.

The Child Health Centers assure provision of direct preventive care services to children with limited access to medical and dental care. These services include child health screening services performed in accordance with the state's EPSDT periodicity schedule. The screening services address the child's and family's psychosocial needs, anticipatory guidance, environmental concerns, and care coordination. Many agencies are providing a broader range of dental health services including oral screening and fluoride varnish application. The agencies integrate immunization, lead screening, nutrition, and WIC services into the local service delivery. Anticipatory guidance emphasizes the importance of age appropriate safety measures. The case management system addresses determination of eligibility, appointment systems with provisions for client recall and follow-up tracking, and referral to other community providers.

School Based Youth Services Programs (SBYSPs). FSB continues its support of Iowa's SBYSPs that are coordinated through the state Department of Education. The SBYSPs projects encourage the establishment of youth centers in or near schools. Through the center, collaborative service delivery is furnished from local providers to children and families. Goals of the programs

are 1) to impact areas with high rates of at-risk teens and children involved with the court system; 2) improve coordination between schools and other service providers; 3) increase the utilization of economic resources by schools to improve the employment and productivity of students leaving school; and 4) increase voluntary use of available services by students and families. Currently twenty-seven individual school districts or consortiums of districts receive state funding. FSB staff assist with the development of the health component of the program and provide technical assistance to local projects, including the promotion of linkage with Title V Child Health programs. During FY99, FSB staff made site reviews to the ten projects newly funded in July 1998. Although local projects were supported by the state appropriations, each project is encouraged to develop local support and financial resources to assure continuation of programming.

Iowa Communities and School Health Promotion Initiative. The goal of this initiative is to increase the number of health-promoting communities and schools in the state. Strategies to meet this goal include: 1) strengthening state agency partnerships to support health promoting communities and schools; 2) building regional and local capacity to advocate for improved community and school health; 3) examining public and private resources for developing community and school health promotion; and 4) using research to improve community and school programs.

The leadership team for this initiative includes representatives from a variety of state departments and includes three members of the FSB. The team meets monthly. The team held a two-day meeting in June of 1999 to assess a sample of district school improvement plans for inclusion of community-school health promotion and school health programs.

FSB staff members have increased their collaborative efforts with the advisory committee for Blank Children's Hospital School Based Health Clinics. FSB is also closely involved with HIV/AIDS education, the Special Education Advisory Panel, and the Occupant Safety Council.

Dental Health Program. The Dental Health Bureau (DHB) of the Division of Family and Community Health provides preventive dental health services that assist the FSB in comprehensive health care effort. To improve the quality and quantity of dental care available to mothers and children, the DHB provides technical assistance, monitoring, training and consultation to all MCH contract agencies. Child health centers receive funding for dental screening and referral for preventive and treatment services. DHB also administers six school-based dental sealant programs, including the federally awarded MCHB grant in Black Hawk County. The child health centers have dental health education and fluoride rinse programs available for elementary school children in rural areas and communities with fluoride-deficient water supplies. The IDPH Division of

Administration and Regulatory Affairs provides technical assistance for the administration of the Community Water Fluoridation Program.

Home Visiting HOPES (Health Opportunities for Parents to Experience Success).
Community Services Bureau administers family centered home visiting program for families of newborns who are identified as at risk for poor outcomes. The model for the HOPES home visiting program is the Healthy Families America program of the National Committee to Prevent Child Abuse. The programs consist of prenatal or birth assessment and services of a paraprofessional partnering with professional support and supervision. HOPES services are available to families in ten counties in Iowa. All families with newborns are linked with appropriate family support, formal or informal, available in the community. The HOPES program is administered through a public/private subcontract with Home Care Iowa Inc.

Healthy Child Care Iowa (SSDI & CISS). Iowa has the highest percentage in the nation of school-aged children with working parents. Iowa also ranks sixth lowest for children who need subsidy for child care and receive it. Of the 199,200 eligible children, only 14,199 are served. The amount of state spending on comprehensive early childhood programs per child was $45.35, while the national average was $76.44. The data clearly shows Iowa has an overwhelming need for healthy and safe child care for children. When a child care environment is licensed or registered, families assume that health and safety standards are in place and the environment is of good quality. However, the quality of child care facilities varies with the resources available to the child care personnel. Child care providers need consistent resources (people and materials) to solve problems or respond to health and safety issues. The Healthy Child Care Iowa (HCCI) campaign is addressing the health and safety needs of children in child care.

Healthy Child Care Iowa is completing the fourth year of operation. Iowa has nine registered nurse child care health consultants (CCHC) working with child care providers. Six CCHCs completed the training with the National Training Institute for Child Care Health Consultants at the University of North Carolina in Chapel Hill. Partnerships are expanding to include Head Start and Early Head Start. The Healthy Child Care Iowa program provides training, technical assistance, and consultation to child care providers. During the past year, 139 training events were offered with 2,513 child care providers participating. The major topic for training and technical assistance is communicable disease prevention. A needs assessment of child care for children with special health or developmental needs was completed and the results can be found in the needs assessment section 3.1.2.3.

HCCI was also included in the RFP for Special Program Considerations. HCCI is a population-based, enabling, and infrastructure building program that focuses on improving the health status of children in child care by developing and supporting the health and safety components of quality child care. The Department seeks to increase the availability of child care health consultants to child care providers throughout the five-year project period. By the end of the project period each contractor will have established a minimum of a part-time child care health consultant (RN) dedicated to HCCI.

Health Leadership Iowa (CISS/COG). The IDPH received a four-year project grant from MCHB, beginning October 1, 1997. The purpose of the grant is to develop the capacity of state and local MCH/CHSC personnel to provide leadership and advocacy for community-based activities that will lead to successful integrated service systems for women and children in Iowa.

The goals and objectives of the program respond to important changes in Iowa's health care environment. The most significant of these changes include welfare reform, managed care, devolution of governmental responsibilities, and changing public attitudes toward government's role in society. The proposed strategies build on existing infrastructure; strengthen state and local partnerships; and develop new, non-traditional partnerships with agencies and organizations apart from the more familiar disciplines of health and social services. The project significantly contributes to the Title V program's capacity for transitioning the public health focus from direct care to core functions. Staff development and technical assistance for state and local personnel proved to be key strategies in the project's first three years.

Abstinence Education Initiative. Iowa continues its participation in the Abstinence Education Program as provided by Section 510 of Title V of the Social Security Act. FSB made continuation funding available to all existing abstinence education contractors through a non-competitive application process for FFY 1999. Contractors have developed three categories of projects including collaborative community-based abstinence only projects, education pilot projects, and community pilot projects, within fourteen maternal health regions. These projects continue to promote asset development in youth and foster communication between children and parents. Contractors deliver abstinence only education through a variety of strategies including informational programs for youth and parents, mentoring programs, development of media resources, and implementation of abstinence only curricula.

FSB held a workshop for all contractors in the fall of 1999. The presenter, Michael Nye of San Antonio, Texas, displayed photographs and played a recorded narrative of men and women who have experienced teen pregnancy. Contractors shared their abstinence programming. FSB promotional materials featuring a "Worth the Wait" message were shared with contractors. The promotional materials were developed by FSB through a cooperative initiative with the Department of Human Services Adolescent Pregnancy Prevention Programs. Iowa's abstinence initiative supports the development of an evaluation component for the education and community pilot projects through an agreement with the University of Iowa School of Social Work. The first report was issued in October 1999. Programs are using the results of the evaluation to strengthen programming.

Child Death Review Team (CDRT). The CDRT reviews death records of all Iowa children, ages birth through six years of age who died during the previous calendar year. This review occurs regardless of where the child dies, and includes out of state children who died in Iowa. FSB has been responsible for CDRT since May 1997. Effective July 1, 1999, the Director of IDPH transferred administrative support from FSB to the Medical Examiner's office. CDRT activities are carried out under a contract with the Iowa SIDS Alliance. CDRT recommendations are coordinated with SIDS Alliance education programs and initiatives. The team has developed recommendations which, if adopted, could lead to a reduction in deaths of children in future years. These are included in Appendix F. A map of the 1998 deaths of Iowa children 6 years of age and younger, by county of residence at time of death, is shown in Appendix G.

Sudden Infant Death Syndrome Program. Autopsies are required by the IDPH on all children two years old and younger who die unexpectedly. State funds are available to reimburse counties for this service. A contractual agreement with the Iowa SIDS Alliance provides for coordination of statewide services which include printed information, presentations to professional and community groups, grief counseling, and referral services for families and related individuals who are involved with the deaths of infants from SIDS. Grief counseling is provided within the county of death by public health nursing or visiting nurses staff. A peer contact (another SIDS parent who is trained in grief support) is assigned to assist the new SIDS family through the first year of grief following the infant's death. Referrals are also made to one of the Iowa SIDS Alliance's six grief support groups throughout the state.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Supplemental Security Income Program. The state CSHCN program provides services to children applying for benefits under the Supplemental Security Income Program (SSI). The

following is a description of capacity to provide services related to the SSI program.

CHSC will maintain information on the number of newly eligible and ineligible children under the age of 16 referred by the state Disability Determination Services Bureau (DDSB) to the Title V program during the year. A letter is sent to each family describing CHSC services and other resources. CHSC can report on the number of SSI acceptances or denials, as well as the number who received services from CHSC. These data are tabulated from the CHSC computerized clinical database.

CHSC will maintain communication and the flow of information with relevant federal, state, and community agencies with respect to SSI. The Title V SSI liaison sends regular updates to CHSC staff and other health professionals who are encouraged to share it with local community agencies. Each Social Security Administration (SSA) office receives information describing CHSC services for distribution to families applying for SSI.

As a result of a multi-state regional meeting in late FY93, an Iowa SSI Collaborative Agency Committee formed to coordinate statewide SSI outreach efforts. This committee is composed of parents and professionals representing numerous agencies (e.g. Head Start; Departments of Education, Human Services, and Public Health; Legal Services Corporation; and DDSB). This committee has not meet in the past two years, but materials are periodically sent to the membership for distribution. The original state SSI liaison retired in 1999 and a new liaison has yet to be identified.

CHSC held discussions with the DDSB, which in Iowa is administered within the Division of Vocational Rehabilitation of the Iowa Department of Education. Previously the CHSC director met with the director of the DDSB to encourage the inclusion of a pediatrician among the panel of physicians reviewing disability applications. A pediatrician was added to that roster in 1989. The CHSC director and Title V SSI liaison have met and established a collaborative relationship with the new DDSB director. CHSC has an agreement (effective 7/1/98 – 6/30/03) with DDSB to assure that clinical services provided by CHSC are known to the DDSB as potential resources for multidisciplinary evaluation. CHSC has also distributed information about SSI eligibility directly to families and collaborating community agencies.

Families of children who are denied eligibility for benefits from SSI are informed about the SSI appeal process and the services CHSC provides. Limited assistance can be provided to assure necessary help and related services. Most assistance is in the form of referrals to community

agencies and providers.

At this time no procedures have been developed to determine specifically what services required by SSI-eligible children are not funded under Title XIX (Medicaid) that might be provided by CHSC. Iowa Medicaid covers most service needs including rehabilitation. Services for unmet needs are requested as exceptions to policy under Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The Iowa Title V program for CSHCN is not a vendor payer program other than for services directly related to provision of clinic care, and certain services for small select populations, such as infants and children with phenylketonuria and cystic fibrosis. The general procedure of contacting families who are newly SSI-eligible (and therefore Medicaid-eligible) should identify the unmet needs of those children and enable an offer of some assistance in obtaining required services.

Rehabilitation services provided by the CHSC program are offered through the multidisciplinary regional Integrated Evaluation and Planning Clinics (IEPC). The service model in the regional centers emphasizes the community provision of health care and related services. As noted above, Iowa Medicaid, for which all Iowa SSI recipients are eligible, covers rehabilitative services.

CHSC Services Overview. The capacity to provide and promote family-centered, community-based, coordinated care for CSHCN rests largely in CHSC's statewide system of regional child health centers. Existent since 1976, the regional child health centers were conceptualized as a multidisciplinary community-based resource for children with complex health and health-related problems. The regional centers support specialized diagnostic and evaluation services, but because the centers are also staffed and advised by community education and human services staff, effective service coordination can occur.

In the early and mid-1980s, needs for additional services such as high-risk infant follow-up and home care planning were identified and the regional centers provided the structure for developing the service system. In the late 1980s, additional providers such as nutrition consultants and parent consultants were trained and assimilated into the regional array of services. Although in varying proportion, each regional center now offers direct clinical services, care coordination services, and family support services. Depending on expressed need and staff availability, professional training and development opportunities are also offered. Following is a description of the capacity to provide family-centered, community-based, coordinated services to CHSCN and their families. Services are classified under the general categories of direct clinical services; care coordination; family support; and training and consultation.

Direct Clinical Services. A variety of diagnostic and evaluation clinics are offered throughout the state. Clinics are staffed by CHSC nursing personnel along with a combination of contracted local providers (physicians and nutritionists), University of Iowa Hospitals and Clinics (UIHC) providers (physicians, physician assistants, nurses, physical therapists, speech pathologists, audiologists, and psychologists), Area Education Agency psychologists, and Department of Human Services social workers. Clinics are held at frequencies ranging from twice each month to twice each year depending on the clinic type and location.

Specialty outreach clinics (mobile clinics) provide pediatric specialty services that are unavailable in local areas or inaccessible to low income families. These clinics may provide follow-up to tertiary level services obtained at UIHC. Regional CHSC nurses and secretaries, UIHC physicians, and other selected professional staff usually staff these clinics. Cardiac clinics evaluate and diagnose heart murmurs and cardiac disease and, where feasible, assist with local coronary prevention programs aimed at reducing the risk of coronary heart disease for children at risk. Orthopaedic clinics provide specialized exams, diagnostic procedures, and intervention recommendations for conditions such as Legg-Perthes', scoliosis, and leg length discrepancy. Ear, nose, and throat clinics serve children who have problems such as chronic hearing loss, chronic ear infection, nasal obstruction, voice problems, anomalies of the head and neck, and problems of airway obstruction. Cystic fibrosis clinics provide interim evaluation, care planning, and counseling for children treated for cystic fibrosis at UIHC. Muscle disorder clinics provide follow-up recommendations for pediatric care, genetic counseling, and physical therapy for children with genetically determined muscle disease, such as muscular dystrophies and atrophies. Pediatric rheumatology clinics evaluate and plan services for children with juvenile rheumatoid arthritis, dermatomyositis, scleroderma, systemic lupus erythematosus, and mixed connective tissue disease. These clinics emphasize the educational and other needs of affected youngsters. Cleft lip and palate clinics serve children who have been previously lost to follow-up or who require ongoing postoperative monitoring, especially for multiple surgical repairs. Diabetes-endocrine clinics provide a complete community-based clinical and educational follow-up for youth with insulin dependent diabetes mellitus seen at the UIHC. The clinic also evaluates growth problems and other endocrine disorders. Hemoglobinopathy comprehensive care clinics provide comprehensive evaluations and family education for children with sickle cell disease, thalassemia, and other hemoglobinopathies. Down's syndrome clinics provide a community-based clinical and educational service for families having a child with Down's syndrome. Gastrointestinal clinics provide evaluation for children with medical problems such as failure-to-thrive, tube feedings, diarrhea, constipation, abdominal pain, liver disease, pancreatitis, and intestinal illnesses, such as Crohn's disease, celiac disease or ulcerative

colitis.

Integrated Evaluation and Planning Clinics (IEPC) (regional clinics) provide a community-based, multidisciplinary clinical evaluation and care planning service for children with any combination of physical, behavioral, emotional, developmental, and learning problems. Clinic staff generally include a CHSC pediatric nurse practitioner or nurse clinician, a contracted medical consultant, a contributed Area Education Agency psychologist and/or speech and hearing professional, a district level Department of Human Services social worker, and other community personnel as needed. The staffing patterns vary according to community preference and personnel availability.

High Risk Infant Follow-Up Program services assess the specialized developmental needs of infants and toddlers who are at-risk due to specific biological factors such as low birth weight. These services are available in nearly all regional centers. Periodic developmental assessments and physical exams are provided by CHSC pediatric nurse practitioners for infants who have received perinatal care in neonatal intensive care units and are determined by established criteria to be at risk for developmental or neurological disabilities. Follow-up visits occur at four, nine, eighteen, and thirty months of age, with a goal of early identification and intervention. Infants, who do not meet strict program eligibility criteria, but are at-risk due to other environmental or familial factors, may still be developmentally monitored.

Care Coordination Services. CHSC defines care coordination services as "services to promote and/or provide for the effective and efficient organization and use of resources to assure access to and use of necessary comprehensive services for children, youth, and young adults with special health care needs and their families" ("CHSC Care Coordination Services for Children with Special Health Care Needs", Report of a CHSC Task Force, 1991). This definition closely resembles that of the MCH Services Block Grant federal reauthorization legislation.

In defining various program activities as care coordination, a broad view of what constitutes care coordination has been adopted. Thus, care coordination can include direct service coordination, guidelines development, service assurance, and technical assistance and consultation. In this context, CHSC provides a variety of care coordination services.

Home and Community Care Planning serves children with very complex chronic health problems and technology-assisted residents and graduates of neonatal and pediatric intensive care units whose families need assistance planning adequate home and community support systems. Examples of health problems of children served by this program include bronchopulmonary

dysplasia, respiratory problems requiring ventilator assistance, complex cardiac conditions, multiple congenital anomalies, feeding difficulties, spinal cord injuries, and severe neurologic or neuromuscular disorders. Home and Community Care Planning is designed to help families assemble services to assure quality home

health care. This may involve locating services, coordinating services, and assisting in evaluating the child's needs.

Since 1985, CHSC has had an agreement with Iowa DHS to assist with the care coordination of children and youth with special health care needs eligible for the Medicaid Home and Community-Based Services Ill and Handicapped (HCBS-IH) Waiver. Over the years, this waiver has grown substantially from the original 50 children and adults served. In July 1997, CHSC began receiving administrative claiming funds to assist with care coordination efforts. These activities continue to expand and constitute greater proportions of all CHSC patient and family contacts. In addition to a growth in numbers, the care coordination process has become more complex due to the health conditions of children served, the shortage of health care providers, and the difficulties of the waiver process. A budget increase from DHS will allow more care coordination services funded under the administrative claiming agreement.

General care coordination is available to all CHSC enrollees. This service is designed to monitor the child's progress and status relative to the proposed care plan. Family needs for obtaining care or managing the child are also monitored. Once CHSC services have been established, staff work with referring professionals, other providers, and families to promote care within a context of changing need.

Other activity-specific care coordination involve the following: 1) school reentry programs for children with cancer (pediatric oncology), insulin dependent diabetes mellitus, or kidney disease (nephrology) where CHSC regional nurses are liaisons between the UIHC tertiary center and the child's local school resources; 2) a hemoglobinopathy comprehensive care program where designated staff assure follow-up services for newborns and children identified with a major hemoglobin disorder; 3) a clinic transportation arrangement where several Department of Human Services district offices transport children and parents to CHSC clinics who otherwise would be unable to attend; 4) a CHSC and Supplemental Security Income (Title XVI) linkage program where a central office pediatric nurse practitioner regularly shares information with families and selected state and local providers (see more extensive description above); 5) a Prader-Willi syndrome community outreach program where a nurse consultant provides training and resources to help develop

community-based services for this population; 6) an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) care coordination service where CHSC regional nurses and designated nurse consultants assist DHS and IDPH staff to provide family support and coordinate multiple home and community services for EPSDT enrollees with special health care needs [Note: Since 10/1/93, CHSC has had an administrative claiming agreement with DHS to serve EPSDT-eligible children with complex special health care needs]; and 7) a hemophilia care coordination service where CHSC regional nurses are liaisons between the UIHC Hemophilia Comprehensive Care Clinic and local communities for the purpose of assisting families of children with hemophilia implement recommendations.

Family Support Services. In keeping with intentions of the federal legislation, CHSC has created opportunities for increased family participation in planning and delivering services to children with special health care needs. The primary motivation for this family-centered emphasis is the recognition that the family is constant in the child's life while the service system and its personnel fluctuate. There is respect for a family's knowledge and ability to determine their own needs. Family-centeredness also honors the racial, ethnic, cultural, and socioeconomic diversity of families. Reviewing and revising opportunities for family participation in all aspects of CHSC planning and programming is currently occurring.

The Parent Partnership Program promotes and supports a number of family-centered activities. The program fosters expanded parent participation in CHSC to better meet families' needs for health and support services. This is accomplished by incorporating parent participation in administrative decision-making, maintaining a statewide parent consultant network, and organizing educational conferences for parents and providers.

The Parent Consultant Network utilizes parents from each of the thirteen CHSC service regions to serve as consultants to other parents and families. The parent consultants work closely with other CHSC regional staff to arrange consultations, which usually entail information sharing, problem solving, or emotional support.

Purchase of Services for Low-Income Families provides family financial support for the prevention of death or disability through purchase of: 1) pancreatic enzymes for children with cystic fibrosis; 2) special dietary formula for mothers and children with inherited metabolic disorders; and 3) diagnostic studies for children with hemophilia at their comprehensive annual exams. There are also limited designated funds for purchasing hearing aids, other equipment, and certain diagnostic evaluations.

IOWA COMPASS Toll-Free Hotline is a statewide information and referral database for people with disabilities, their families, and other community members. It is partially supported by CHSC with programmatic information and an annual financial contribution for operations maintenance. The database maintains extensive information on over 9,000 organizations that directly or indirectly serve individuals with disabilities. Information is maintained in 28 major service categories that subsume over 380 specific services.

Training and Consultation Services. Aside from clinical, coordination, and support services for families, CHSC staff are involved with training and consultation activities designed to improve service system quality and capacity. These efforts are appropriate because 1) organizationally, CHSC is a program within a university teaching hospital pediatrics department, and 2) by mandate, as a state Title V program, CHSC must assume leadership in promoting and establishing statewide service system development. Below are descriptions of ongoing training and consultation services.

Infant and Toddler Services are a cooperative early intervention effort with the Bureau of Special Education of the Iowa Department of Education to implement the Early ACCESS Program (Part C of the Individuals with Disabilities Education Act). CHSC's consultant provides training and technical assistance to community projects and assists CHSC staff to explore and understand their roles in Part C. Other consultant activities include developing and promoting family-centered policies, developing and distributing resource materials, and facilitating interagency collaboration.

Regional Autism Services Program is supported by the Bureau of Special Education of the Iowa Department of Education and involves activities emphasizing training community-based Autism Resource Teams to better meet the needs of children with autism and their families. Linkages for collaborative support and initiatives exist with the Autism Society of Iowa and the Iowa Department of Human Services. Behavior management strategies, social skills development, and vocational training are the major training content areas. Provision of resource materials and program guidelines supplement the training. Also, CHSC regional offices offer an autism screening service for children 3-13 years old to advance early identification and early intervention services.

Nutrition Consultation Services are available to local primary providers, including follow-up of children and families evaluated by tertiary level nutrition staff. Expected nutrition problems include failure-to-thrive, feeding difficulties, and special energy and nutrient considerations. CHSC, the Iowa University Affiliated Program, and the Iowa Department of Public Health cooperatively plan training for regional nutrition consultants.

Speech/Language Consultation services are available to Area Education Agency personnel who want consultation for children with complex communication needs. Consultations are scheduled so children can be examined individually by the CHSC consultant in the presence of the local speech/language clinician and at least one parent. Findings and recommendations are then jointly discussed.

Other Training and Consultation Activities include the following: 1) spinal screener training where CHSC nurses provide technical assistance to school-based spinal screeners to help develop confidence and skill in screening techniques and referral procedures; 2) nursing student training where CHSC nursing and support staff help teach baccalaureate, associate degree, and pediatric nurse practitioner nursing program students who visit selected CHSC clinic practicum sites; 3) enhancement of school health services where a) several CHSC regional nurses serve on Area Education Agency consultation teams concerned with school health services for children with special health care needs, and b) CHSC supports a school nurse consultant in Area Education Agency 5 as an information resource and service planner for students with special health care needs not otherwise eligible for special education services; 4) MCH leadership training as part of the ILEND project (Iowa Leadership Education in Neurodevelopmental Disabilities)in collaboration with the Iowa University Affiliated Program where trainees are invited – some with financial support – to witness and participate in a variety of CHSC clinical and program planning activities to help develop leadership intentions and skills; and 5) consultation to child care providers as part of the Healthy Child Care Iowa project where providers are assisted with issues related to children with special health care needs.

Iowa Leadership Education in Neurodevelopmental and Related Disabilities (ILEND): The purpose of ILEND is to educate and develop leaders who will improve health and enhance systems of care for children with special health care needs, and for their families, through graduate education and post-graduate training continuing education, technical assistance, and consultation. Iowa's Title V advisory board provides recommendations regarding the curriculum and project implementation.

In addition, the following ILEND activities are accomplished in collaboration with IDPH:

- Consultation regarding health planning and initiatives of the Family Services Bureau of the Iowa Department of Public Health to the ILEND project.
- Training activities for ILEND trainees about core public health services, community planning and maternal and child health issues.

- Facilitation of community-based opportunities for ILEND trainees to observe leadership activities and public policy development.
- Development and promotion of a prevention agenda for children with or at risk for Neurodevelopmental disabilities.

Iowa's University Affiliated Program (IUAP): The IUAP focuses on building community capacity, so that all Iowans, including Iowans with disabilities, can participate as members of their communities. Goals center on self-determination, education of students of the health professions, health, employment, housing, and community support. In addition, the IUAP serves as a statewide resource for training, service, technical assistance, research, and information sharing.

The following IUAP activities are accomplished in collaboration with IDPH:

- Provision of training and technical assistance to Iowa state agencies, hospitals, Area Education Agencies, and professional organizations regarding the need for their support of the Statewide Hearing Detection and Follow-up program to ensure that every Iowa newborn is assessed.
- Support for the activities of the Iowa Prevention of Disabilities Policy Council to address state-level policy issues and facilitate the development of collaborative research, training and service initiatives related to the prevention of disabilities;
- Support for projects to increase access and improve the quality of health care for Iowa children, including children with disabilities;
- Provision of ongoing information and training to local providers of EPSDT's informing, case management, screening and treatment services;
- Provision of community-based technical assistance for a number of public health and maternal and child health issues including local community-based system development;
- Provision of two state MCH continuing education events each year; and
- Provision of technical assistance to IDPH grantees to develop capacity of current MCH personnel to provide leadership and direction in the development of effective, integrated community-based systems of care.

1.5.1.3 Other Capacity

The administrative office for Iowa's Title V program is located in the Capitol Complex in close proximity to the State Capitol, in Des Moines, Iowa. The IDPH employs the Family Services Bureau Chief, a Division Medical Director, and twenty-four professional and support staff who carry out the functions of Iowa's Title V program. The department contracts with 26 maternal health and 26 child health agencies to provide community-based MCH services throughout the state (see maps located in Appendices C and E). For additional information see sections 1.5.1.1 and

1.5.1.2. Responsibility for coordinating the program for CSHCN is an administrative responsibility of the FCH division and is under contract to the University of Iowa, Department of Pediatrics.

CHSC has both central and regional staff. The table of organization (Appendix B) indicates all staff by position. Of the total staff complement, 28 are housed in the central administrative offices in Iowa City. The remaining 34 staff are housed in or associated with the 14 regional centers. The regional centers are located in the state's population centers. Most Iowans are within a one hour drive from a regional center. Planning, evaluation, and data analysis functions are shared among professional and support staff. One professional staff member has educational and experiential background in epidemiology and evaluation and is designated to take a lead role in coordinating like activities. Parents of CSHCN are specifically represented on staff by one permanent FTE family support program coordinator in the central office and 13 contracted parent consultants affiliated with the regional centers and the central office (Appendix H). The family support program coordinator oversees the statewide network of parent consultants by designing training, monitoring activity, and updating resource information. The parent consultants all undergo a structured training experience to prepare them for their roles as information resources, problem solving assistants, and peer supports.

As of the present time, there has been one substantial administrative change within the CHSC structure. A new "Policy and Planning Unit" has been created using existing staff. The unit is responsible for performing a variety of infrastructure building activities, as well as providing other central and regional office staff with training opportunities for increasing infrastructure building skills. There are additional, not yet implemented, administrative changes being considered for the purpose of facilitating the programmatic shift from direct care provision toward service coordination and infrastructure building. Although specifics are currently unknown, the changes will generally support the decentralization of services in order to match other state "devolution" initiatives. Some of these changes may be finalized during the early part of FFY2001.

Appendix I contains brief biographies of senior level management staff, including Dr. Edward Schor, M. Jane Borst, Dr. Jeffrey Lobas, and Lucia Dhooge.

1.5.2 State Agency Coordination

The following descriptions highlight significant linkages with other IDPH programs. The programs listed here are not intended to represent a comprehensive listing of the extensive coordination efforts undertaken by the state's Title V program. Additionally, a listing of formal and informal organizational relationships with social services including Medicaid and child welfare, education,

local public health agencies including community based private nonprofit agencies, and other related agencies is located in Appendix J.

Preventable Diseases Program. The Division of Health Protection, Immunization Bureau, administers the program for vaccine preventable diseases. This bureau is part of the Family and Community Health Division. Vaccines are made available to local health departments and child health centers for all required childhood immunizations. The implementation of the Iowa State Immunization Information System, a computer-based registry, is now serving the public sector clinics. While progress is slow, plans are underway to update the registry software and make it available to the private practice sector. The computer system will enable the state to acquire population-based immunization data. At the present time the only avenue to obtain the population based information is to access the Centers for Disease Control (CDC) data. The FSB continues to collaborate with its contractors, the Immunization Bureau, and the Department of Human Services to promote the statewide implementation of the registry in both the public and private sector.

Childhood Lead Poisoning Prevention Program. Children are screened by Title V child health programs, physicians, and local health departments. Of the children tested, 12.4% were identified as lead-poisoned, which is nearly three times the national average of 4.4% as reported by Phase II of the Third National Health and Nutrition Examination Survey. Based on the fact that 42.9% of Iowa's housing was built prior to 1950, the IDPH continues to recommend that all children under the age of six years receive routine blood lead testing. Through continuing education programs IDPH educates office staff and practitioners from private practice about the importance of screening for lead poisoning. IDPH Lead Poisoning Prevention Program and FSB have helped Title V child health program obtain physician cooperation in completing lead screening. The Title V Child Health agencies, local health departments, IDPH, and community-based Child Health Lead Poisoning Prevention Programs (CLPPP) coordinate the medical and environmental case management of children with lead poisoning.

Iowa Birth Defects Institute. The 1976 Iowa legislature created the Birth Defects Institute (BDI) within IDPH. In the ensuing years the BDI, in partnership with the University of Iowa and health care providers throughout the state, has developed programs providing Iowans with state of the art genetics health care. There are five programs within the BDI: the Regional Genetic Consultation Service (RGCS), the Iowa Newborn Metabolic Screening Program (INMSP), the Maternal Serum Alphafetoprotein Screening Program (MSAFP), the Neuromuscular and Related Genetic Disorders Program, and the Iowa Birth Defects Registry (BDR). Newborn metabolic screenings are done for five disorders: phenylketunria, galactosemia, congenital hypothyroidism,

hemoglobinopathies, and congenital adrenal hyperplasia. A pilot project is underway for a sixth disorder, medium chain acetyl-CoA dehydrogenase. IDPH provides oversight to the five BDI programs with assistance from the Birth Defects Advisory Committee. The committee is composed of representatives of the programs, various professional health care groups, consumers, two legislators, a CHSC representative, and IDPH staff. All BDI programs, with the exception of the Iowa BDR, are funded by either state appropriations or fee-for-service payments. The Iowa BDR is funded primarily by grant funding from the Centers for Disease Control and Prevention.

Unintentional Injury Prevention. Staff members from FSB collaborate with the Governor's Traffic Safety Bureau on the Children/Youth Occupant Safety Leadership Committee. The name of the committee was changed from the Car Seat Task Force to reflect the change in focus to all children and youth vehicle related injuries and fatalities. In FFY99 the Governor's Traffic Safety Bureau funded a full time position in the Bureau of Emergency Medical Services (EMS). The position coordinates efforts to provide communities with technical assistance regarding education and enforcement of child safety seat usage. Iowa's seat belt usage increased to 78% in FFY99. FSB coordinates with EMS regarding injury prevention on the "Love Our Kids" Task Force. "Love Our Kids" license plates are sold throughout the state, and proceeds fund statewide injury prevention projects. FSB collaborates with the Bureau of Disability Prevention within IDPH.

EPSDT Care for Kids. FSB provides services for the EPSDT *Care for Kids* program. Under an agreement with DHS, child health centers are approved as EPSDT screening centers. Child health centers are making efforts to assure that children have medical homes. To ensure that children receive the comprehensive screening requirements of the program, EPSDT care coordinators have developed partnerships with local physicians. In FFY99 the screening program emphasized improving access to dental health services to assure that children receive at least one EPSDT preventive dental visit. On a quarterly basis the IDPH receives a report from Consultec, DHS fiscal agent, identifying the immunization services billed to Medicaid. A pilot project was conducted by two Title V contract agencies using the electronic file to compare records held in the agency with the Medicaid data. The projects confirm the need to coordinate at a higher level with the immunization registry. FSB will receive an electronic monthly download from the immunization registry to input into the child health database that is being developed. The database will be implemented statewide and will have the capacity of joining the Medicaid children with the Title V child health clients. The database should assist local agencies in efforts to coordinate care for the entire child population in their service area and improve documentation of the compliance rate for these children.

Each month EPSDT local care coordinators call families newly enrolled in Medicaid to inform them about the need for immunizations, dental visits, and periodic well child visits. The statewide Healthy Family Line (1-800 number) links families with the EPSDT care coordinator. A designated care coordinator contacts families to provide support and assist with reducing barriers to access medical and dental care services.

With implementation of the HAWK-I program, community based agencies work directly with families to assist them with enrollment. The statewide enrollment is currently 13%. Through implementation of the Iowa Covering Kids project, Robert Wood Johnson Foundation Grant, IDPH has improved access to the HAWK-I program.

FSB staff members provide technical assistance to community-based EPSDT care coordinators in developing care coordination skills, determining the cost for informing and care coordination activities, utilizing computer support for the software program, and facilitating community meetings with counties that had total EPSDT participation rates below 80%. Training workshops are held annually. EPSDT care coordinators receive orientation and updated information on care coordination, computer software changes, and program development.

Comprehensive School Health Initiative. A project begun in 1998 to develop a resource for communities and school districts to implement community-school health advisory councils is nearing completion. The project represents a collaborative effort between public agencies, private entities, and corporate sponsors, including Blank Children's Hospital, Iowa Health Systems, Pioneer Hi-Bred International, Inc., and the American Cancer Society. The Iowa Coalition for Comprehensive School Health has been approached for support. The Title V block grant has contributed funding and staff time toward the development of this project. The American Cancer Society is funding six pilot projects throughout the state that will begin in the fall of 1999. An application for funding as a pilot site was sent to each school superintendent in May of 1999. Local American Cancer Society volunteers and staff members of Iowa State University Extension will assist pilot projects at the local level. MCH contractors will be encouraged to participate in the pilot projects and in their local district's efforts. A statewide meeting is planned to promote the development of new councils and provide support for those already in existence.

Early ACCESS. Early ACCESS is a federal program under the Individuals with Disabilities Education Act (IDEA, Part C). In Iowa the program is an interagency collaboration between the Iowa Department of Education, the IDPH, the Department of Human Services, and CHSC. The system is a partnership between families with young children, birth to age three, and providers

from local public health, human service, education, and child health specialty agencies. Partnerships also exist for families with other public or private service and resource providers. The Iowa Department of Education is the lead agency, as appointed by the Governor of Iowa for the implementation and maintenance of this system. A state level multidisciplinary council, the Iowa Council for Early Intervention Services (ICEIS), advises and assists the Iowa Department of Education in the implementation of Early Access.

DHS Cooperative Agreement. IDPH Family and Community Health Division maintains an ongoing Cooperative Agreement with the Department of Human Services, Division of Medical Services. The agreement reflects cooperative efforts toward an integrated system of high quality, comprehensive, cost-effective, adequately financed health services for mutual beneficiaries. The agreement is renewed annually and is available upon request.

Federally Qualified Health Centers. The state of Iowa currently has four designated Federally Qualified Health Centers (FQHC). Two of the four designated centers have subcontracts with IDPH for community based child health centers. The remaining two FQHCs continue to be involved in community collaboration with the designated Title V agencies in their area. In addition to the four existing centers, two new centers are in planning stages in Council Bluffs and Ottumwa. Local Title V agencies actively participated in the efforts to establish these new centers.

Child Health Specialty Clinics. CHSC's central administrative offices are located at the University of Iowa Hospitals and Clinics. This proximity provides a wealth of tertiary level pediatric expertise that can be shared with CHSC's central and regional office staff. Continuing education programming has been delivered at the University, at community sites, and over the statewide fiberoptic communication network. Direct service mobile specialty clinics, enabling service care coordination collaborations, and infrastructure building planning activities provide an opportunity for students of health professions to become familiar with issues and logistics related to community-based health care service delivery. CHSC's relationship with the University also finds benefit in the tapping of information technology resources, financial management services, public policy expertise, and research design and program evaluation consultation.

CHSC maintains several pertinent interagency agreements with state entities. The following list indicates the agencies with which CHSC maintains agreements and summarizes the purpose of each agreement.

- The IDPH/FCH: to promote development of a cooperative and collaborative relationship at state and local levels through cross-referrals, sharing of staff, coordinating staff training, and interfacing data systems;
- The Iowa Department of Education Division of Vocational Rehabilitation Disability Determination Services Bureau: to define responsibilities of the parties related to applicants and recipients under age 16 of the Supplemental Security Income Program (SSI) and under age 22 who need specialized health services regardless of SSI eligibility;
- The Iowa Department of Human Services: to define responsibilities of the parties in assessment, planning, and care coordination activities for recipients of the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) of the Iowa Medical Assistance Program (Title XIX);
- The Iowa Department of Human Services: to define responsibilities of the parties in assessment, planning, and care coordination activities for applicants and recipients of the Home and Community-Based Services (HCBS) – Ill and Handicapped Waiver Program of the Iowa Medical Assistance Program (Title XIX); and
- The Iowa Departments of Public Health, Education, and Human Services and the Office of the Lieutenant Governor: to delineate the roles and responsibilities of each of the parties related to the implementation of the provisions of I.D.E.A., Part C including principles of family involvement, coordination of resources, and nonduplication of services.

2.1 Annual Expenditures

See Forms, 3, 4, and 5

Title V partnership expenditures in FFY 1999 totaled $13,266,026. Expenditures from the MCH Block grant are reported at $6,511,115 and state match for Title V is reported at $5,662,635. The match amount exceeds the required state match and the maintenance of effort. Federal Title V funds expended for child health primary and preventive care were $2,141,441 which represents thirty-three percent (33%) of block grant expenditures for the year. Administration expenditures of $329,597 represent 5% of the federal Title V amount.

Expenditures for each of the population groups served were slightly less than the amount budgeted. Overall, Title V partnership expenditures were eight percent (8%) below budget. The variance appears to be primarily attributable to several vacant positions and less than anticipated expenses submitted by local, community-based contractors.

A summary table listing the budget and expenditures follows:

	DPH & Administration	CHSC	TOTAL

	Budget	Actual	Budget	Actual	Budget	Actual
Infrastructure	$2,177,044	$1,807,799	$1,005,101	$851,709	$3,182,145	$2,659,508
Population Based	$642,246	$706,404	$404,292	$460,161	$1,046,538	$1,166,565
Enabling	$160,699	$184,562	$798,279	$988,907	$958,978	$1,173,469
Direct Care	$6,171,660	$5,778,867	$2,956,803	$2,487,617	$9,128,463	$8,266,484
Total	$9,151,649	$8,477,632	$5,164,475	$4,788,394	$14,316,124	$13,266,026

Direct Care. Expenditures in this category include local level maternal and child health primary and preventive care (including dental care and care coordination), home visiting, and genetic services. It also includes state funds used to pay for deliveries not covered by other public assistance program, SIDS autopsies, and the prevention of repetitive premature births project. IDPH expenditures in this category were 6% less than the budget amount. The variance is primarily attributed to local contract MCH agencies expending less than the amounts allocated during their one year contract period. CHSC expenditures were 16% less than budget.

Enabling Services. Expenditures in this category include maternal and child health outreach strategies including the toll free information and referral phone line, home care, and care coordination for children with special needs. Expenditures in this category exceed the original budget by 13%. This reflects an increase in operating costs for the toll free information and referral service.

Population-based Services. Expenditures in this category include population-based disease prevention programs for sexually transmitted disease, immunizations, and children with special needs population based activities. Expenditures exceeded budget by 11%. The variance is attributable to an increase in CHSC state level expenditure.

Infrastructure Building Services. Expenditures in this category include IPDH state level MCH and dental staff, some CHSC staff, the statewide perinatal review team and infant mortality prevention programs, the Council on Chemically Exposed Infants and Children, Barriers to Prenatal Care Survey, and the contract for the child health systems development consultant with the IUAP. Expenditures were 16% below budget. Expenditures within the FSB and CHSC for personnel and related support were less than anticipated.

2.2 Annual Number of Individuals Served

See Forms 6-9.

2.3 State Summary Profile

See Form 10.

2.4 Progress On Annual Performance Measures

The annual plan for FFY99 placed an emphasis on developing core public health functions and responding to reforms in the health care delivery system. As a rural state with substantial shortages of medical services and maldistribution of existing services, Iowa is challenged to develop systematic approaches to population based maternal and child health while maintaining essential community-based direct care services. General categories of program activities included assessment, identification of needs for culturally diverse groups, improved access to services, addressing changes brought about by managed care, interagency collaboration, policy development, and direct clinical and care coordination services. Additionally, activities for CSHCN focused on assuring specialty services to children and families, integrating data systems, balancing private and public partnerships, and integrating community-based services.

In the FFY99 performance measures and the Electronic Reporting Program (ERP), 1999 provisional data from the Vital Records was collected on April 17th, 2000 and was used for the reporting of some performance measures. It is labeled on the performance measures and ERP notes when provisional data was used for reporting of FFY99.

This report discusses Iowa's progress toward the eighteen National Performance Measures (NPM) and ten negotiated State Performance Measures (SPM).

Direct Care

NPM #1 The percent of state SSI beneficiaries <16 years old receiving rehabilitative services from the state CSHCN program. (FFY99 performance objective = 90 percent)

The target objective of 90% for this measure was met (FFY99 indicator value = 92%). In Iowa, all children receiving benefits from the SSI program are automatically eligible for Medicaid benefits and CHSC's role is to encourage families receiving SSI to apply for Medicaid, as formal application is required despite benefits being guaranteed. CHSC is committed to work with the Iowa Department of Human Services to determine if there are rehabilitation services required by SSI beneficiaries that are not covered by Medicaid. At this time, the adopted definition for what constitutes "rehabilitation services" includes direct health care, as well as care coordination, outreach, and informing services. The coordinator of CHSC's Home and Community Care Planning Program has accepted responsibility to monitor this performance measure.

NPM #2 The degree to which the state CSHCN program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. (FFY99 performance objective = 9).

The target objective of 9 was met (FFY99 indicator value = 9 out of a possible 9 specialty services provided by the CSHCN program). Services substantially provided or paid for by CHSC are done so either through direct service provision, service coordination, or facilitation of services. CHSC continues to collaborate with other provider programs, including public and private third party payers, to monitor the service system and to plan and advocate for services from all nine categories to be accessible and meet quality standards. The CHSC program director has accepted responsibility to monitor this performance measure.

SPM #1 Percent of children served under Title V and Title XIX who have a documented need for mental health/behavioral services who receive care from a service provider specializing in child and adolescent mental/behavioral health (FFY99 performance objective =55 percent) This SPM has been discontinued.

The performance objective of 55% was not met (FFY99 indicator value = 27 percent). The FFY99 indicator value decreased from the FFY98 value and continued to be based on recall estimates and chart review by CHSC regional health service coordinators. A designated work group was planned and formed to address issues related to this performance measure, but was relatively inactive. Issues addressed included the wording of the performance measure and operationalizing definitions for "specializing in child and adolescent mental / behavioral health", "mental / behavioral health providers", "documented need", and "receive care." Based on the definitions, formal assessments of Title V and Title XIX experiences were intended. A notable activity related to improving statewide mental health services for children did occur. It involved preliminary deliberations for a grant proposal to investigate the influences of local care coordination and provider education on clinical outcomes, service utilization patterns, and service costs for children with behavior disorders and other mental health conditions.

SPM#2 Percent of women enrolled in Medicaid who received enhanced services during their pregnancy. (FFY99 performance objective = 35 percent) This SPM has been discontinued.

Data from Iowa's Medicaid/Birth Certificate Matching File Analysis provide information on benefits of enhanced services to pregnant women. The most recent year for which data are available is

calendar year 1997. In 1997, there were 11,217 Medicaid paid deliveries in Iowa (30.6% of all deliveries). The percent of these Medicaid women who received Medicaid enhanced services was 27.1% (n=3040). This is a decrease from 40.9% in 1995 and 34.4% in 1996. The reason for this decline is unclear. In 1999, a basic review of Medicaid Risk Assessment forms from four maternal contract agencies demonstrated that 65% of their maternal health clients were scored as high risk. All of these women were reported as having received enhanced services through the agency. A comparison was made of the rate of low birth weight live births in counties served by these reporting agencies prior to the implementation of enhanced services in 1993, and after the provision of enhanced services. In 1993 the average rate of low birth weight births for these areas was 6.4%, and in 1997 the rate for the same areas was 6.0%. The rate of clients receiving prenatal care in the first trimester was 86% in 1993, and had increased to 89% by 1997. Data was retrieved from IHITS, Iowa Health Indicator Tracking System, for 1993 and 1997. The enhanced services package continues to demonstrate improved birth weight and adequacy of prenatal care. Infants born to these women tended to weigh slightly more than infants born to women who had not received these services. As noted in the first paragraph, these rates appear to be eroding, perhaps as a consequence of the movement to Medicaid managed care and HMO coverage. The department has assisted the twenty-six community-based Title V agencies in their collaboration with the Medicaid managed care organizations to provide a comprehensive prenatal care package for the Medicaid pregnant population.

Medicaid claims data are made available to IDPH for the purpose of analysis. The process of sorting and matching files is labor intensive. The IDHS funds this project through a Medicaid administrative agreement.

Enabling Services

NPM #3 The percent of CSHCN in the state who have a "medical/health home." (FFY99 performance objective = 30 percent)

The performance objective of 30% was met (FFY99 indicator value = 70 percent) as determined by a FFY99 random survey sample of CHSC patients in two pilot counties (one urban and one rural). The families received services in CHSC clinics in FFY98 and were asked about the availability of a physician for their child 24 hrs/day, 7 days/wk, 52 wks/yr, and within 45 minutes travel time. This is a simplified version of the medical/health home definition offered by the American Academy of Pediatrics. Of 73 total families surveyed, 51 reported the above criteria for physician availability. The simplified definition will be expanded as part of the statewide population-based Iowa Household Health Survey that is scheduled to be completed in FFY01. The expanded definition will probably

cause the percentage to decrease in the immediate subsequent years. A work group has been formed and will plan future statewide assessments as well as interventions to enhance medical/health home opportunities.

SPM #3 Percent of children served by Title V, excluding CSHCN, who report a medical home. (FFY99 performance objective =30 percent)

Title V community-based child health centers in Iowa served 18,430 children in 1999. Of those children, it was determined that 85% had a medical home. The data reporting difficulty that was reported in 1998 still exists. The Iowa Department of Public Health is currently in the process of developing a child health database that will eliminate some of the data reporting difficulties. For the purpose of addressing this performance measure for 1999, the state developed a standard definition for medical home, identified how the current data system could support data reporting, and determined a standard method for data reporting using the current Patient Service Record (PSR) data system. The training that the Title V local contractors received in 1998 in regards to the definition of medical home and how to report the data using the PSR system remains valid. IDPH continues to work with community entities, child care resource and referral, and Head Start to improve data reporting.

The data source for the performance measure is the current Iowa Department of Public Health and the Patient Service Record (PSR) main frame data system.

SPM #4 Proportion of low income children, MCH eligible, ages 1-4 referred from child health centers who have completed a referral to a dentist. (FFY99 performance objective =16 percent)

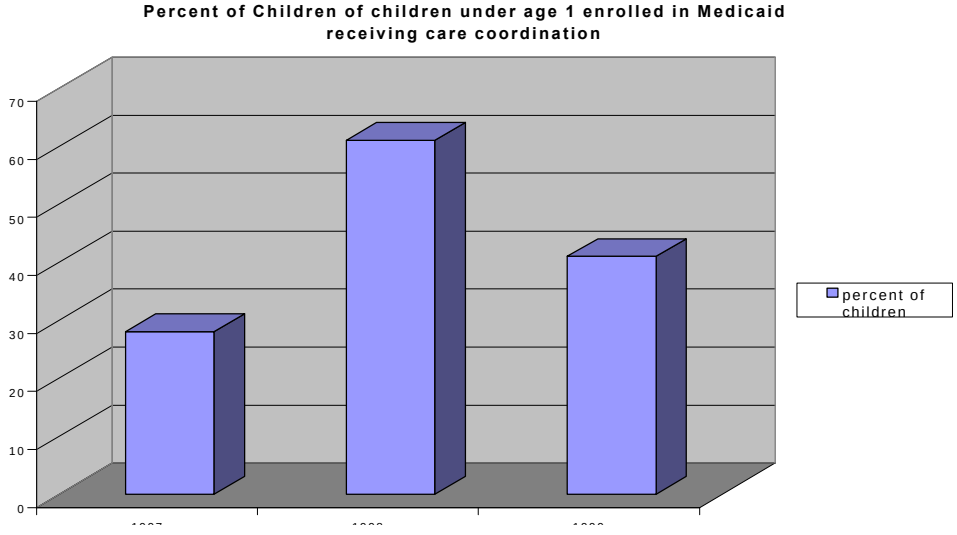
The FFY99 performance objective of 16% was not met (FFY99 indicator value = 7 percent). This was the same proportion that completed a referral in the previous year. Efforts were made to increase care coordination activities by the local child health centers during the year. However, many of the same barriers to the access to dental care for children on the Title XIX program exist for these children. The Title XIX dental fee schedule is used for reimbursing dentists for treating children supported by Title V funds. These fees are approximately 50% of dentists' usual and customary charges. In addition, dentists claim pre-authorization, slow turn around time on claims, frequent broken appointments, and other patient compliance issues for reasons they are reluctant to treat Title XIX patients. Dentists use many of the same reasons for not wishing to participate with the Title V program. Despite efforts to provide support services to families and care coordination, Title V families exhibit many of the same compliance problems for dentists. Until the state

legislature increases fees to an acceptable level it is not likely that problems with access to dental care for these children will improve significantly.

Dental Health Bureau staff provides technical assistance to Iowa ABCD programs whose primary goal is to establish a dental home for low-income children. The Dental Health Bureau works closely with child health agencies to encourage care coordination and advocacy for low-income children to seek and complete dental treatment.

SPM #5 Percent of CSHCN in the state enrolled in managed care plans who have a written plan of shared management protocols and protocol monitoring. (FFY99 performance objective = 20 percent) This state performance measure has been discontinued.
It is assumed that the performance objective of 20% was not met (FFY99 indicator value = 10 percent). New data for this performance measure was not obtained in FFY99 and no progress occurred in actually instituting the use of shared management protocols within managed care plans. The performance measure is a direct result of the widespread concern that CSHCN enrolled in managed care plans may not receive optimum care. The shared management protocol concept addressed these deficiencies with a planned approach to managing the care of CSHCN. Within this framework, CHSC proposes to collaborate with the Iowa Department of Human Services (DHS) and their Medicaid managed care contract organizations to develop and promote the use of quality measures and standards, possibly to include use of shared management protocols. As a result of regular collaboration between the CHSC program director and the DHS Medicaid director, the issue assumed a broader scale in FFY99. Through a more global approach, the agencies sought to determine how CSHCN were currently served under managed care contracts. Regular discussions between CHSC and DHS related to this performance measure have promoted interagency understanding and a collaborative relationship.

SPM #6 Percent of children under age 1 year enrolled in Medicaid who receive care coordination



services. (FFY99 performance objective = 40 percent) This SPM has been discontinued.
In 1999 the percent of Medicaid enrolled children under age one, receiving care coordination decreased from 61% in 1998 to 41%. This decrease can be explained by the assumption in 1998 that Medicaid eligible children who were enrolled in a managed care plan were receiving care coordination because it was covered under capitation fees. In 1999, IDPH received the encounter data, which represented claims for the HMO clientele. The number of enrolled recipients in 1999 under one year old in managed care was 11,106 (38%) of the total Medicaid recipients in the age group, 28,746.

After reviewing the data, it was discovered that managed care plans are not required to break out care coordination services from the capitation rate. This made it difficult to determine the number of care coordination services.

IDPH decided to use EPSDT screening codes for the HMO clients in attempt to determine a rate of service. It was assumed that if a child received an EPSDT screen there was some level of care coordination. The formula that is used to calculate the percentage is HMO screens (5,917) + Public Health care coordination claims (5,854) divided by EPSDT total eligible clients in the 1 year old group (28,746), which equals 41%.

Twenty-six community-based Title V contract agencies provide care coordination services in all 99 counties in Iowa for Medicaid enrolled children except for enrollees in managed care and children in foster care. The community programs continue to develop the capacity of their organization to provide services to families. Community linkages for referrals and coordination of service delivery are areas showing continual improvement.

Family Service Bureau staff has provided ongoing technical assistance to guide the development of service coordination. FSB conducted a two-day workshop in May 1999. This workshop focused on different strategies to assist the local care coordinators in their efforts to link the families with the needed services. The second day of the workshop was devoted to training the care coordinators of the local agencies about the computer software improvements that supports this activity.

The computer software that was developed at the IDPH is housed in all 26 Title V contract agencies, covering the 99 Iowa counties. This is a tracking system to assist the agencies to locate and coordinate care for the Medicaid clients in their area.

Data Sources:

Medicaid claims, managed care encounter data and the Medicaid enrollee file.

Population Based

NPM #4 Percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, glactosemia, hemoglobinopathies (e.g., the sickle cell diseases).
(FFY99 performance objective = 99.2 percent)

Data provided to the Birth Defects Institute by the Iowa Neonatal Metabolic Screening Program indicate that more than 99% of all Iowa newborns are screened for genetic and metabolic conditions. Data also indicates that 100% of those infants, who screen positive and are confirmed to have a disorder, receive treatment and follow-up services. The number of newborns and children receiving services has steadily increased since 1992.

In addition to the metabolic screening program, the Birth Defects Institute provides oversight for other screening and genetic services. Activities and services provided in 1998 and 1999 are as follows. The Expanded MSAFP Screening Program provided services to 15,181 pregnant women. One case of open spina bifida was detected per 33 women with persistent MSAFP elevations, while one in 14 patients with elevated MSAFP values was carrying a fetus with a defined fetal anomaly. The Birth Defects Institute completed a survey of activities related to promotion and use of folic acid periconceptionally. Quarterly meetings of the Birth Defects Advisory Committee continued. A new position for a state genetics coordinator was developed and an individual was hired to assume these responsibilities.

Comprehensive genetic health care services were provided in 86 statewide outreach clinics through a contract with the University of Iowa. There were 1,017 patient visits, with 56.3% of the visits for new patients. A total of 2,813 people attended 83 educational presentations conducted by genetics staff. Efforts continued to further develop a statewide outreach cancer genetic consultation and counseling program, with specific arrangements with one local cancer center completed. Clinical services were provided to 351 neuromuscular patients and families in eight outreach clinics, as well as at clinics at the University of Iowa.

NPM #5 Percent of children through age two who have completed immunizations for measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, Haemophilus influenza, and Hepatitis B.
(FFY99 performance objective = 82 percent)

The results of the 1999 assessments found that 86% of the children assessed in the public health sector have reached this important goal. Forty-eight public sector immunization clinics have

attained 90% coverage levels in 1999. To continue to maintain this high level of immunization coverage, counties advertise in fliers, local cable TV, shoppers, etc. WIC clinics screen the immunization records of the children they serve. There were 584 records reviewed and of those, 525 (90%) were found to show the immunizations complete. A total of 584 immunizations were given at seven WIC clinics.

The state has a toll free hotline, Healthy Family Line, which provided information on immunizations to 18 families this past year. For the first time, the 1999 assessments on the Iowa State Immunization Information System were completed through the extraction of immunization data from the state's immunization registry. This registry serves the public sector clinics, and steps are underway to update this system which will make it available to the private practice sector. The Family Service Bureau and Immunization Bureau are collaborating to implement the new child health database to aid in tracking all Iowa's children by October 2000. Collaboration is underway with the Immunization Bureau to enable the immunization registry to do a monthly download of the registry's files to this new child health database. This will aid the state in its efforts to acquire population-based data. At the present time the only avenue to obtain the population-based numbers is to access the National Immunization Survey conducted by CDC. In addition, the IDPH receives a quarterly file from Medicaid's fiscal agent showing the Medicaid eligible children who are not up-to-date on their immunizations. This is an important mechanism for aiding the IDPH/FSB and the 26 child health contract agencies in assisting families and children to obtain the needed immunizations.

The data sources for the performance measure are the IDPH, Immunization Bureau, and CDC. The goal is to rely on the immunization registry, ISIIS, Iowa State Immunization Information Systems, for ongoing reporting of this performance measure. FSB continues to collaborate with its contractors, the Immunization Bureau, and the Department of Human Services to promote the statewide implementation of the registry in both the public and private sector.

NPM #6 The birth rate (per 1,000) for teenagers aged 15 through 17 years.
(FFY99 performance objective = 21.8 percent)

The performance objective for the birthrate of teenagers aged 15-17 years old for 1999 provisional data exceeded the objective at 18.2%. A major focus of Title X funding is to reach teenagers aged 15-17 and increase efforts to engage teenage males through outreach and educational programs. It is estimated that 800-1,000 outreach and educational programs are provided throughout the state by the Title X programs of the Iowa Department of Public Health. The educational programs stress

the value of abstinence, encourages adolescents to talk with their parents about sexuality issues, emphasize responsible decision making skills, and provide information related to pregnancy and STD prevention including information about all contraceptive methods in order to make an informed choice.

Iowa also continues its participation in the Abstinence Education Program as provided by Section 510 of Title V of the Social Security Act. Continuation funding was made available to all 20 existing abstinence education contractors through a non-competitive application process for FFY99. Program development continues within three categories of projects including 1) collaborative community based abstinence only initiatives within 14 Title V maternal regions; 2) 4 education pilots projects; and 3) 2 community pilots projects. The projects promote asset development for youth and foster communication between children and parents. Abstinence only education is delivered through a variety of strategies including informational programs for youth and parents, mentoring programs, development of media resources, and implementation of abstinence only curricula.

NPM #7 Percent of third grade children who have received protective sealants on at least one permanent molar tooth. (FFY99 performance objective = 46 percent)

A statewide survey of third grade children (in school year 1999-00) to determine the prevalence of dental sealants indicated that 38.9 % have at least one dental sealant in a permanent molar tooth. The same survey also indicates that 37% of Iowa's third graders don't have dental insurance. The survey indicates that it has been more than three years since 12.1% of the third graders have seen a dentist. This survey will allow the establishment of a statewide sealant database in future years. Survey methodology and additional findings are reported in Appendix K.

NPM #8 The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. (FFY99 performance objective = 5.9 percent)

The 1999 provisional data rate for deaths to children ages 1-14 caused by motor vehicle crashes per 100,000 children was 1.1.

The revenues collected from the "Love Our Kids" license plates continue to increase and provided funding in 1999 for 24 projects focusing on intentional and unintentional injuries to children. The grants awarded in 1999 totaled $28,650.00 and included child passenger safety, fire safety, sports safety, bicycling safety, camping safety, farm safety, and two projects on multiple safety issues.

The IDPH and the Bureau of Emergency Medical Services have been working in partnership with the Governor's Traffic Safety Bureau to establish a network of trained technicians in all 99 counties. Six NHTSA, (National Highway Traffic Safety Administration), Standardized Child Passenger Safety Technicians trainings have been held since October 1998. There are currently 167 certified technicians with various professional backgrounds across the state. The certified technicians work with Love Our Kids grantees, local Safe Kids Coalitions and other community organizations to promote education and demonstration of correct safety seat usage.

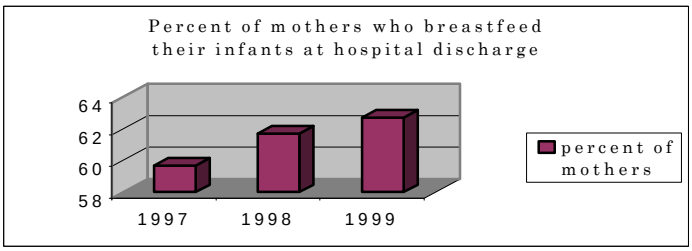
The University of Iowa Injury Prevention Research Center conducted the 1999 Iowa Child Passenger Restraint Survey. There were 6,210 children under the age of six who were observed in motor vehicles at 37 locations across the state. A total of 74.8% were judged to be properly restrained, which is an increase of 1.6% from the 1998 survey. The seat belt usage survey conducted by troopers of the Iowa State Patrol, Department of Public Safety, indicated that 78% of motorists surveyed on Iowa roadways were wearing seat belts, an increase of 1.1% from 1998. County roads, where one-third of all motor vehicle crash fatalities occur, had a 13% increase in seat belt usage over last year. For improved seat belt usage to continue, increased enforcement and public education on the importance of safety belt and child safety seat usage needs to occur.

Iowa has initiated efforts through legislation, bike rodeos, and safety town demonstrations to educate children concerning bike safety and helmet usage. However, Iowa still has does not have a law that requires riders to wear bike helmets. There were six grants awarded to local communities to provide educational programs. During the Register's Annual Great Bike Ride Across Iowa (RAGBRAI) each summer, the Ride Right program which emphasizes bike safety and helmet usage and is sponsored by the Des Moines Register, is promoted by bike clubs.

The cities of Davenport, Sioux City and Waterloo have initiated the Safe Communities approach to local injury prevention reduction. During this next year, plans are to work with four additional communities to initiate the Safe Communities program.

There are currently 80 Safe Communities contacts in the state of Iowa. The cities of Davenport, Sioux City, and Waterloo have fully initiated the Safe Communities approach to local injury prevention reduction. During this next year, plans are to work with four additional communities to initiate the Safe Communities program.

NPM #9 Increase the percentage of mothers who breastfeed their infants at hospital discharge. (FFY99 performance objective = 59.1 percent)



In 1999 62.7% of Iowa mothers were breastfeeding at hospital discharge. The data source for breastfeeding rates at hospital discharge is an item on the metabolic screening form. This information is collected at the time of the newborn metabolic screen and forwarded from the University Hygienic Lab to the Nutrition and WIC Bureau for monitoring. The maternal health nurse consultant collaborates with Nutrition and WIC staff in implementing breastfeeding initiatives.

Breastfeeding activities for 1999 included the annual breastfeeding conference with joint sponsorship between IDPH and Iowa Health Systems. Additionally, efforts continued on the distribution of educational materials to MCH agencies, WIC agencies, and breastfeeding coalitions. Three representatives from the Iowa Department of Public Health continued to participate and collaborate with the Iowa Lactation Task Force. The statewide task force's mission is to provide, promote, and coordinate breastfeeding education, support, and evaluate through local coalitions, health care providers, and educational institutions. The initial National Breastfeeding Promotion Campaign in 1997 included promotion of breastfeeding through billboards and T.V. This campaign continued in 1998, with the addition of radio and newspaper public service spots. The annual breastfeeding workshop was held for local agency staff.

Breastfeeding is emphasized in the partnership between Title V and the child care system. Materials were disseminated to regionally based childcare health consultants to share with personnel in the Child and Adult Food Care Program. WIC supported a portion of an FTE registered/licensed dietitian to the Healthy Child Care Iowa campaign.

NPM #10 Percentage of newborns who have been screened for hearing impairment before hospital discharge. (FFY99 performance objective = 60 percent)

The performance objective of 60% was not met. As of September 1999, 74 Iowa hospitals, out of the 94 hospitals delivering babies, were providing newborn hearing screenings. Of these 74 hospitals, 94% of their newborns were screened for congenital hearing loss in 1999. The Iowa Department of Public Health encourages Iowa hospitals to adopt newborn hearing screening for all newborns prior to discharge.

A statewide data management and tracking system is being developed through collaborative efforts of Part C, Title V, and the University of Iowa Hospital School. This initiative is part of Early ACCESS, formerly known as Iowa's System of Early Intervention Services, Iowa's Part C of IDEA program, and will become an important tool for early identification of children with hearing impairments.

SPM #7 Percent of infants identified in the state as high risk receiving follow-up (or appropriate discharge) at age 30 months. (FFY99 performance objective =60 percent) This SPM has been discontinued.

It is estimated that the performance objective of 60% was not met (FFY99 indicator value = 53 percent). It is felt that this may be because infants who were referred because of maternal substance abuse during pregnancy frequently fail to show for appointments. There seems to be increasing numbers of these children being identified. There is a concern that there is a larger group of infants who are at risk for future developmental problems due to other than physiological causes, namely environmental and social, who may not meet the criteria of the High Risk Infant Follow-up Program. There is currently no known statewide system for documenting and tracking this group, although the Early ACCESS Program (Part C of the Individuals with Disabilities Education Act) is planning a statewide enrollment and monitoring system. A CHSC work group was formed in FFY99 and met to look at more systematic way of identifying outcomes for infants and toddlers who experience any of a specifically defined array of "risk" exposures. The group has not reached any definite conclusions. The group feels this performance measure should continue to be a priority issue. The group suggests the need to capture data to more accurately to reflect the numbers identified and served. The definition of "at risk" must still be reviewed. Ideally, data should be collected and shared by other agencies serving "at risk" infants and toddlers to ascertain if there are "holes" in the system. There also continues to be concern about how best to coordinate the various early identification and intervention programs serving infants and toddlers in order to more effectively assess and improve statewide outcomes.

Infrastructure Building

NPM #11 The percent of CSHCN in the state CSHCN program with a source of insurance for primary and specialty care. (FFY99 performance objective = 90 percent)

The performance objective of 90% was met (FFY99 indicator value = 92 percent). To make this indicator value estimate, it is assumed that the 51% of CHSC patients for whom insurance status was unknown would proportionally resemble the patient group for whom insurance status was known. A work group has been formed and is developing procedures for collecting insurance status information on all CSHC families to increase data accuracy.

NPM #12 Percent of children without health insurance. (FFY 99 performance objective = 8 percent)

During the 1996-1998 time period, an estimated 6.3% of children under 19 at or below 200 % of poverty were not covered by private or public health insurance. The state children's health insurance program, entitled HAWK-I was implemented January 1999 in 16 counties and statewide March 1, 1999. Medicaid expansion was implemented July 1, 1998. During 1998 -1999, Title V staff provided key leadership in the state on outreach strategies for HAWK-I by coordinating with community-based agencies, and school-based and child care staff.

Between September 1998 and September 1999, three significant policy changes have occurred to Medicaid and HAWK-I: 1) the removal of the required face-to-face interview for Medicaid; 2) removal of the assets test for Medicaid; and 3) adding a 20% earned income deduction to HAWK-I. These three changes have helped streamlined Medicaid and HAWK-I by simplifying the enrollment process and making application procedures more uniform between the two programs. As of September 1999, enrollment for Medicaid expansion was 8,515 and HAWK-I was 2,809.

The Title V Agencies that are pilot sites have aided in infrastructure building by changing policy in simplification and mainstreaming of Medicaid and HAWK-I. The sites have also played a significant role in population-based and enabling services by providing health coverage and a medical home for children.

In July 1999, the Family Services Bureau, Title V Administrator, became a grantee for the Iowa Covering Kids Project, a national initiative to increase access to health care for low-income children. The three goals for this project are to: 1) design and conduct outreach programs in pilot communities that identify and enroll eligible children into Medicaid and HAWK-I; 2) simplify the

enrollment process; and 3) coordinate existing coverage programs for low-income children. Refer back to 1.4 Overview of the State for more information.

Data Source: US Census Bureau Report

NPM #13 Percent of potentially eligible children who have received a service paid by the Medicaid program. (FFY99 performance objective = 82 percent)

During FFY99, 84% of Iowa children eligible for Medicaid at some time during the year received a service paid for by Medicaid. In FFY98 there was an decrease from 93% to 79% of children 1-5 years of age that received at least one EPSDT screen. The percent of children 6-14 years of age that were screened also decreased from 167% to 89%. This percentage is over 100% because the Medicaid 416 report counts multiple screens throughout the year.

Emphasis has been placed on outreach activities for getting children enrolled in Medicaid and for assuring they have access to services once enrolled. Title V child health clinics screened families for Medicaid and Hawk-I eligibility. The child care consultants in the four regions of the state informed registered and licensed child care providers and the Child Care Resource and Referral agencies about the need for immunizations, periodic well child visits, HAWK-I eligibility guidelines, and Medicaid/HAWK-I enrollment procedures. Over one half of Iowa's counties have established agreements for Medicaid Administrative Claiming which facilitates potentially Medicaid-eligible families and assists families gain access to services.

Access to dental health services continues to be an improvement in the state. Only 33 percent of eligible children received a least one EPSDT preventive dental service in FFY98. In FFY99 the Iowa Department of Public Health (Dental Bureau) initiated the Access to Baby & Child Dentistry (ABCD) program in two Title V agencies that represent two different areas of the state. The Iowa ABCD program is modeled after the program in Spokane, Washington. The Iowa ABCD program will work with the Medicaid population as well as the local dental providers in an effort to improve the dental access for children. The success of this program will be evaluated through quarterly reports from the two Title V contract agencies who are conducting the pilot. In addition to the ABCD program, Iowa has eight Title V contract agencies who have applied for "Exception to Policy" to reimburse dental hygienists in child health screening centers to screen children age one to three year.

In the spring of 1999 workshops were held in four regions of the state for Title V contract agency staff who provide care coordination services. The emphasis of the workshop, "Building Connections to Care," was building awareness of the way culture influences people's behavior, strategies for connecting with "hard to reach" populations, and improving communication skills. During this year, many child health contractors have begun transitioning Medicaid eligible children to medical homes with private practices within local communities. This magnifies the importance of care coordination efforts by *Care for Kids* coordinators to assure that these children continue to receive preventive services according to the periodicity schedule.

The EPSDT *Care for Kids,* a quarterly newsletter, was distributed to health, social service, and early education professionals, health care providers, legislative representatives, and schools. Issues featured such topics as strategies to help providers reduce missed appointments and Iowa's new children's health insurance program. The Healthy Families Line is a 1-800 number through which families can access the *Care for Kids* Coordinator in their local community. Last year there were 2,394 calls to the Healthy Families Line regarding the *Care for Kids* program.

The data sources for the performance measure are Medicaid claims data for FY99 and the Medicaid Management Information System Annual EPSDT Participation Report "HCFA – 416" dated 10/01/98 – 09/30/99.

NPM #14 The degree to which the state assures family participation in program and policy activities in the state CSHCN program. (FFY99 performance objective =12 points)

The performance objective of 12 was not met (FFY99 indicator value = 9 out of a possible 18 family participation points). CHSC continues its decade-long commitment to family participation in program and policy activities; however, there was no minority representation on the CHSC Parent Consultant Network during FFY99 resulting in a decrease in indicator value from the previous year. In addition, FFY99 was a planning year for the parent consultant network. A combined task force of nurses and parent consultants canvassed their colleagues on issues such as consultant qualifications, duties, and supervision. The expertise of the parent consultants is valued at all levels of the organization and planning is currently underway for a complete restructuring of the CHSC Parent Consultant Network to ensure systems-level participation in all program and policy activities.

NPM #15 Percent of very low birth weight live births. (FFY99 performance objective =1.4 percent)

In 1998 the emphasis for reducing the incidence of very low birth weight was placed on reducing racial disparities. The five-year goals and objectives seek to reduce Iowa's low birth weight rate to an incidence of no more than 5% of live births and the very low birth weight rate to no more than 1% of live births by September 30, 2000. The Black population was identified as a special target.

Low Birth Weight (LBW)

Year	Black Live Births	Black LBW Infants	Rate Black LBW Per 100 Live Births
1993	1,385	162	11.7
1994	1,050	138	13.1
1995	987	111	11.2
1996	1,045	154	14.7
1997	1,093	116	10.6
1998	1,081	142	13.1
1998	1,152	145	12.6

Source: Iowa Vital Statistics 1993-1999 provisional data

Very Low Birth Weight (VLBW)

Year	Black Live Births	Black VLBW Infants	Rate Black VLBW Per 100 Live Births
1993	1,385	33	2.4
1994	1,050	26	2.5
1995	987	27	2.7
1996	1,045	40	3.8
1997	1,093	29	2.7
1998	1,081	45	4.2
1999	1,152	27	2.3

Source: Iowa Vital Statistics 1993-1999 provisional data

The five-year goals have not been met, but significant improvement is noted from 1998.

NPM #16 The rate (per 100,000) of suicide deaths among youths 15-19. (FFY99 performance objective =13.7 percent)

The provisional 1999 rate per 100,000 of suicide deaths among youth ages 15-19 is 9.7, less than both the FFY99 goal of 13.7 and the 2001 goal of 13.9.

The FFY99 Annual Plan addressed this performance measure by noting that although youth suicide rates is a targeted objective identified by MCHB, it is not within IDPH programming assigned to FSB. Throughout FFY99, the Bureau continued to advocate for appropriate programming.

An increase in the suicide rate among youth ages 15-19 was noted from 1996 to 1998, followed by a significant decrease in 1999. The following table displays data collected in 1996 and subsequent years.

Suicide Death Rate for Youth Ages 15-19

Year	Rate per 100,000
1996	11.4
1997	15.0
1998	19.4
1999 (Provisional data)	9.7

Source of data: *Vital Statistics*

Iowa's Title V MCH programs incorporate a social assessment that can facilitate identification of teen stress and depression and result in appropriate care coordination. Screening and referral for psycho-social health issues is a service provided by EPSDT programs.

Iowa's twenty-seven School Based Youth Services Programs (SBYSP) require a mental health component, which typically results in linkages established with local mental health providers. FSB staff participated as members of the state support team for SBYSP. School staff assisted in identification of problems that can lead to improved communication among schools, families, and mental health professionals. Increasingly, schools are implementing programs and curricula addressing appropriate ways to handle stress and manage conflict.

The TEEN Line and Healthy Families Line are phone line services that provide information and referral to callers statewide. Linkages are made with local resources when mental health issues are addressed. Information regarding services provided by the TEEN Line and Healthy Families Line is disseminated at numerous conferences statewide. Newly designed posters and brochures have improved marketing efforts. Information on these resources have also been made available through the IDPH website.

Improved education for providers on screening tools, coordination of care, and follow-through can direct needed attention to teen suicide. Care coordination/case management ensures that services are provided to clients who are involved in diverse service systems such as the schools, courts, social services, mental health services, and Medicaid. Ideally, a system of care coordination/case management reflects community based planning which results in designated responsibility for services addressing mental health issues. A coordinated effort is needed from a variety of fronts- families, schools, communities, service organizations, and professionals- to continue to impact the rate of teen suicide.

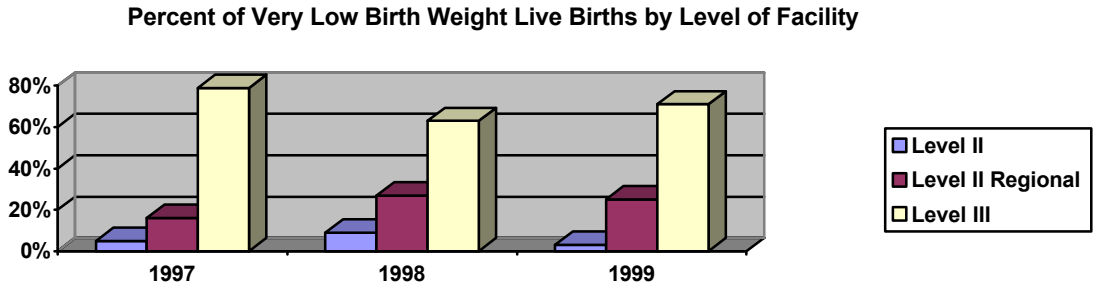
NPM #17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. (FFY99 performance objective =80.1 percent)

The percent of very low birth weight infants delivered at Level III facilities decreased from 77.8% in 1996 to 61.1% in 1999. This may be due in part to the development of the designation of Level II Regional facilities, which may provide "competition" for the Level III Centers for high-risk clients (chart 2). The number of recognized Level III perinatal centers remained at 3, while there are 7 Level II Regional facilities. The state continued the established contract with the Iowa Statewide Perinatal Care Program. Completed activities included the following: regular meetings of the Perinatal Guidelines Advisory Committee; consultation to all Level II, Level II Regional and Level II hospital nurseries and obstetrical departments on a bi-annual basis; administrative consultation to hospital and health related groups; coordination with the High-Risk Infant Follow-up Program; monitor annual volume of deliveries at Level II, Level II Regional and Level III perinatal centers; on-site review of medical records; assessment of educational needs and planning and presentation of educational programs; and publishing the Iowa Perinatal Newsletter on a quarterly basis.

Very Low Birth Weight Infants Born in Iowa Tertiary Perinatal Centers

Level III Perinatal Center	Number of very low birth weight births 1998	Number of very low birth weight births 1999
Iowa Methodist Medical Center, Des Moines	38	40
Mercy Hospital Medical Center, Des Moines	96	90
University of Iowa Hospitals and Clinics, Iowa City	152	105
Total: State of Iowa	286	235

CHART TWO (Source: Vital Records)



NMP #18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

By September 30, 2000, increase the proportion of all pregnant women in Iowa who receive prenatal care in the first trimester of pregnancy from 86% in 1993 to 90 percent or above.

First Trimester Entry into Prenatal Care (all residents)

Year	Percent of women entering care in first trimester
1993	86.9%
1994	87.5%
1995	85.8%
1996	85.8%
1997	86.2%
1998	86.3%
1999	86.7%

Source: Iowa Vital Statistics 1993-1999 provisional data

In 1998, Iowa also established a more specific annual objective: By September 1998, increase the proportion of Black pregnant women entering prenatal care in the first trimester from 56% in 1993 to 73%. This objective is aimed at eliminating disparities, and targets the population of pregnant Black women. This objective was met in 1999, and progress continues to be positive.

First Trimester Entry into Prenatal Care (Black Women)

Year	Total Births to Black Mothers	Black Women Entering Care in the First Trimester	Percent of Black Women Entering Care in the First Trimester
1993	1,385	773	55.8
1994	1,050	729	69.4
1995	987	696	70.5
1996	1,045	760	72.7
1997	1,093	803	73.5
1998	1,081	787	72.8
1999	1,152	848	73.6

Source: Iowa Vital Statistics 1993-1999 provisional data

According to the 1998 Iowa Barriers to Prenatal Care Project statewide, pregnant women self report a rate of 91% receiving prenatal care in the first trimester.

Lack of early prenatal care is a multifaceted problem. A single cause for lack of prenatal care has not been determined.

Direct care and enabling services program activities were provided by 26 contracted community-based agencies serving all 99 counties. Prior to 1997, funds were not available to Linn and Johnson counties, and Polk County had not been included in the funding formula. Agencies provide services to facilitate early entry into prenatal care including Medicaid presumptive eligibility determination, care coordination and case management including follow-up, and outreach with a focus on high-risk women. Agencies also identified strategies for coordinating with other community programs. Special emphasis was placed on building linkages with Title X Family Planning services.

SPM #9 Degree to which Iowa's providers of general care services to children with special health care needs use quality improvement measures in their practices. (FFY99 performance objective =7 points)

The performance objective for this performance measure was not met (FFY indicator value = 5 out of a possible 12 quality improvement measures points). This measure is a rough estimate based on some experience with and knowledge of primary medical care providers with whom CHSC has a relationship. A work group has been formed to plan and undertake a more complete surveillance of quality improvement activities, as well as a review of the performance measure checklist's suitability. The work group developed a new tool to evaluate the use of quality improvement measures among providers of medical care for CSHCN. A secondary purpose of the tool is to give examples of quality measures that can be easily incorporated into the practice of private physicians. The tool was piloted first with the Executive Board of the Iowa Chapter of the American Academy of Pediatrics and then with physicians who provide contractual services to CHSC. The survey target population is all Iowa pediatricians (n = 188) and all Iowa family practice physicians (n = 1,145). Results of the survey will be reported in progress report for FFY00.

SCALE SCORE FOR QUALITY IMPROVEMENT MEASURES IN A GENERAL PEDIATRIC PRACTICE SERVING CSHCN

Score is for Federal Fiscal Year: 1999
Score Interpretation:

Point Value Scores for a Specific Quality Item	% of Most Favorable Score for a Specific Quality Item
1	0-9%
2	10-19%
3	20-29%
4	30-39%
5	40-49%
6	50-59%
7	60-69%
8	70-79%

9	80-89%
10	90-100%

Score Range for Each Question: 1-10

Score Range for the Sum of 7 Questions: 7-70

Quality Items and Point Value Scores:

QUALITY ITEM	POINT VALUE SCORE
How often are services you provide covered by plans with built-in quality assurance measures?	7
How often do you solicit feedback from your patients and families regarding their satisfaction with services provided by your practice?	7
How often do you assign a specific office nurse to be the liaison between the family and your practice?	5
How often do you obtain and review medical or health care records from other providers?	9
How often do you involve families in the decision-making for their children's care?	10
How often do you meet or talk with other professionals (e.g. therapist, teacher, nutritionist, home health nurse, etc) involved in the child's care?	7
How often would it be helpful to have the IFSP (from Part C) and the IEP (from Special Education) in the medical record?	9

TOTAL SCORE (score range is 7 to 70 points) (Note: this score is reported on Form 11)	**54**

SPM #10 Percent of children who are obese. (FFY99 performance objective =9.3 percent)
This SPM has been discontinued.

The Pediatric Nutrition Surveillance System (PEDNSS) data indicates that the prevalence in Iowa of overweight children up to five years of age has increased steadily from 7.6% in 1985 to 10.1% in 1999. In 1999, 34.2% of youth participating in the Youth Risk Behavior Survey (YRBS), reported they were overweight, while only 8% were actually overweight based on the BMI calculated from self reported weights and heights. Students from alternative schools were also used in the study, and 12% of the students were determined to be overweight. The effort to deliver consistent and compelling messages to improve the nutritional health and increase physical activity of children is coordinated through the Child and Adolescent Obesity Task Force, representing MCH, WIC, Head Start, and the Child and Adult Care Food Program.

The Iowa Nutrition Education Network (INEN), the umbrella organization for nutrition coalitions in the state, focuses on successful and practical approaches to prevention, with an emphasis on promoting healthy weights for children through sound nutrition choices and regular physical activity.

The Pediatric Nutrition Surveillance System, along with the Iowa Youth Risk Behavior Survey will monitor this performance measure.

SPM #8 The degree to which the state develops a data system for strategic assessment of the health of women, children and families. (FFY99 performance objective =14)

Considerable progress was accomplished for this performance measure. Thirty-four (34) points were achieved on the rating scale using the new instrument that was updated and revised for FFY01. Progress is largely attributable to work completed through the Health Leadership Iowa (CISS-COG) grant initiative. In April 1999, DPH provided 32 regional MCH contract agencies and CHSC staff with *Child and Family Health Profiles* for each of Iowa's ninety-nine (99) counties. The documents were developed through collaborative efforts with Iowa Sate University Extension. Data sets highlighted in the profiles are identified in Table 1.

Table 1

Category of Data Set	Data Set	Comparisons
Demographic	Age Distribution Population w/o Health Insurance Minority Enrollment in Public Schools Limited English Proficiency Public School Students who Drop-Out Health Professional Shortage Area	County/State Comparisons
Infant Health & Well-Being	Low Birth Weight Rate Infant Death Rate Number of Births per Year	County/State Comparisons 5-Year Trends
Child Health & Well-Being	Immunization Rates-Children under Age 2 Child Population at or Below 185% Poverty	County/State Comparisons
Maternal Health & Well-Being	Mothers Who Smoke & Drink during Pregnancy Pregnant Women Receiving Enhanced Services D Births from Unintended Pregnancies STD Rates Positive Urine Toxicologies	County/State Comparisons Region/State Comparisons

Profiles were distributed at a statewide meeting that provided opportunities for community based staff to practice using data to contribute to community planning efforts. "Storytelling" techniques were presented and simulations were practiced. Local MCH contractors were directed to disseminate the profiles to local boards of health and share county level stories regarding the MCH

population. Follow-up surveys to collect feedback regarding use of the data were conducted at 2 months and 6 months following the conference. Responses suggest that the profiles were used extensively in the preparation of the county needs assessment (*"Community Health Needs Assessment and Health Improvement Plan"* – CHNA-HIP) as well as development of both the 1999 and 2000 MCH and FP community-based program plans.

Data for CSHCN also were identified during this FFY. Demographic data identifying this population were available for use and distribution. Health care utilization and behavioral risk factors for psycho-social and socio-economic factors were analyzed. In FFY98 the CSCHN group of data was inadvertently omitted. Consequently the score reported was artificially low.

As discussed elsewhere in this document (Needs Assessment) the state's current State Systems Development Initiative (SSDI) which began October 1, 1999 seeks to further develop capacity for collecting, managing, analyzing and utilizing key data related to the health of families. It is expected that these data will be available in FFY 2001.

Health Status of Women, Children, and Families
Checklist for Data System Development

0 = data not collected (ex: data not available, data obtainable but of poor quality, data not obtained due to lack of resources)
1 = data collected (ex: measurement instruments and procedures identified, frequency of obtaining measurements determined)
2 = data managed (ex: database structure developed, editing and report functions designed, data put into usable form)
3 = data analyzed (ex: data sorted or manipulated, statistical procedures applied, charts or graphs created)
4 = data utilized (ex: data used in program planning, policy formulation, oral/written presentation, or funding request)

- **Maternal Health**

Demographic	0	1	2	3	[4]
Risk factors	0	1	2	3	[4]
Health care utilization 0	1	2	[3]	4	
Health status	0	1	2	[3]	4

- **Infant Health**

Demographic	0	1	2	[3]	4
Risk factors	0	[1]	2	3	4
Health care utilization 0	[1]	2	3	4	
Health status	0	1	2	[3]	4

- **Child Health**

Demographic	0	1	2	3	[4]
Risk factors	0	[1]	2	3	4
Health care utilization [0]	1	2	3	4	
Health status	[0]	1	2	3	4

- **Adolescent Health**

Demographic	0	1	2	3	4
Risk factors	0	1	2	3	4
Health care utilization 0	1	2	3	4	
Health status	0	1	2	3	4

- **Health of CSHCN**

Demographic	0	1	2	3	4
Risk factors	0	1	2	3	4
Health care utilization 0	1	2	3	4	
Health status	0	1	2	3	4

- **Family Health**

Demographic	0	1	2	3	4
Risk factors	0	1	2	3	4
Health care utilization 0	1	2	3	4	
Health status	0	1	2	3	4

***NOTE*: Total Score must range from 0 to 96**

Examples:

Demographic (race, ethnicity, age, gender, income, marital status)

Risk factors (smoking, exercise, weight, nutrition, family history, environmental/occupational exposures, family stress)

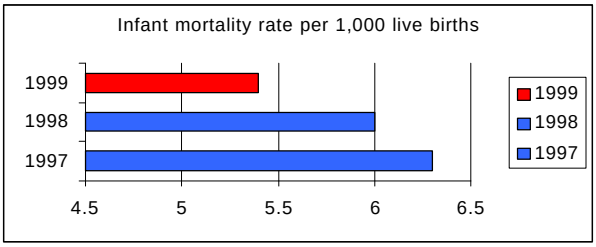
Health care utilization (insurance status, preventive health care, immunizations, primary physician, dental care, specialty care)

Health status (diagnosis, functional limitations, work/school absence, hospitalizations, use of medications/medical equipment

2.5 Progress On Outcome Measures

This report discusses Iowa's progress toward the six National Performance Outcome Measures. No additional state outcome measures were added. Following the report is a review of Annual Objectives included in the FFY 2001 Plan that are not addressed by National Performance Outcome Measures.

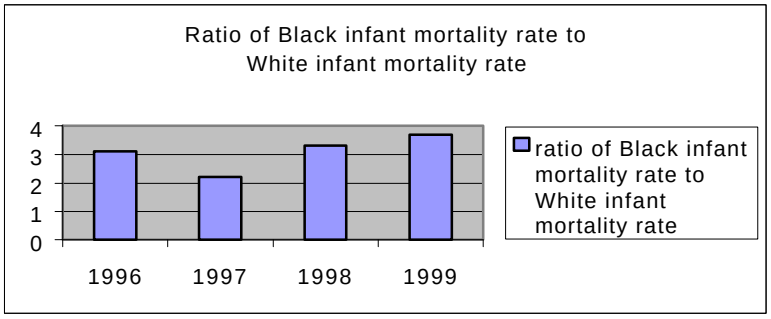
OM# 1 The infant mortality rate per 1,000 live births. (FFY99 target=7.0)



The total infant mortality rate for Iowa shows a decrease for 1999. The rate for 1997 was 6.3, 1998 6.0 and 1999 provisional data is 5.4.

National Performance measures 4, 5, 9, 13, 15, 17, 18 and State Performance Measure 3 contribute to achieving this Outcome Measure.

OM# 2 The ratio of the Black infant mortality rate to the White infant mortality rate. (FFY99 target=2.4)



The target of FFY99 was not met (target=2.4). Despite the activities of the Infant Mortality Prevention Center, and Healthy Start of Visiting Nurse Services of Polk County, the state has thus far been unable to significantly decrease the numbers of deaths to black infants. Small numbers for minority populations continue to present challenges for effective monitoring of this objective. Dr. Stephen Gleason, Director of the Iowa Department of Public Health, established the Minority Health Advisory Committee in February 2000. Part of the charge of this task force is to investigate the disparities in minority infant mortality rates and make recommendations to the Governor's office. State and National Performance Measures also address increasing outreach to minority populations and cultural competence for health care providers is ongoing, including action plans specific to health disparities written by the state's maternal and child health contractors.

OM# 3 The neonatal mortality rate per 1,000 live births. (FFY99 target=4.6)

The neonatal mortality rate for 1999 provisional data was 3.2 per 1,000 live births. If forecast methods for neonatal mortality are accurate in projecting a trend, the state can expect a continued rise in rates. The total number of live births in the state continues to decrease, while infant deaths continue to gradually rise. Strategies and recommendations developed by the Iowa CDRT (see OM #6) will also be used for neonatal mortality.

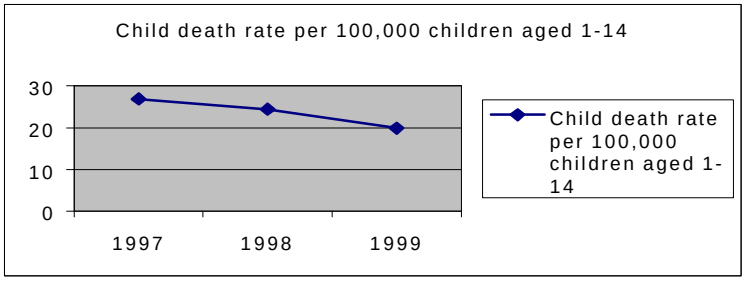
OM# 4 The postneonatal mortality rate per 1,000 live births. (FFY99 target=2.0)

The number of postneonatal deaths jumped from 1.9 deaths per l,000 live births in 1998 to 2.2 deaths in 1999. Performance measures as identified in Outcome Measure #1 apply.

OM# 5 The perinatal mortality rate per 1,000 live births. (FFY99 target=10.3)

Perinatal mortality rates showed a decrease from 1998. Data indicate a rate of 9.7 per 1,000 live births in 1998 and a 1999 provisional rate of 9.2.

OM# 6 The child death rate per 100,000 children aged 1-14. (FFY99 target=24.8)



The total number of child deaths slightly decreased in CY99 provisional data from 145 in 1998 to 105. The rate decreased from 24.4 to 19.1 per 100,000 children. Efforts to prevent unintentional injury of children and adolescents are currently concentrated in the IDPH Bureau of Disability and Injury Prevention.

Activities of the Child Death Review Team continue to identify causes and recommendations for the reduction of child deaths throughout the state. Recommendations from the Iowa Child Death Review Team can be found in Appendix F.

National Performance Measures 4, 5, 8, 12, and 13 and State Performance Measures 1, 2, and 6 contribute to achieve this Outcome Measure.

3.1 Needs Assessment Of The Maternal And Child Health Population

3.1.1 Needs Assessment Process

The Iowa Department of Public Health Family Services Bureau (FSB) and Child Health Specialty Clinics (CHSC) embarked on a five-year needs assessment, beginning in November, 1999 with a day-long retreat involving key administrative and staff personnel from both agencies. At that time, the state began preparation of a comprehensive assessment to identify the need in Iowa for:

- preventive and primary care services for pregnant women, mothers and infants,

- preventive and primary care services for children, and
- services for children with special health care needs.

Participants at the first meeting created a master timeline to coordinate needs assessment activities. Both FSB and CHSC agencies identified the staff who would ensure adherence to the timeline. Throughout the ensuing months, the two agencies worked in close collaboration, meeting regularly to coordinate need prioritization processes and to determine the resultant state performance measures to be utilized in Iowa during the next five-year period (FFY2001-2006). FSB and CHSC staff chose prioritization methods with the capacity to assess the need for direct health care, enabling, population-based, and infrastructure building services. The staff held discussions regarding public and private collaboration, state and local government linkage, and citizen and family involvement in the needs assessment process.

A perceived strength of the needs assessment process was the amount of the input from all levels of Title V state and local stakeholder agencies. Stakeholders gave input through verbal discussion, written survey, prioritization exercise, multivoting technique, and consensus building. Staff used both qualitative and quantitative methods to gather input. Different groups, working independently, identified similar issues when ranking the top three priority needs. A perceived weakness of the process was the lack of broadbased involvement from parents of children with special health care needs due to the restructuring of CHSC family participation described in national performance measure #14. However, parents including those of CSHCN were involved at the level of the MCH Advisory Council.

Throughout the needs assessment process, the MCH Advisory Council was advised of the needs assessment activities and invited to actively participate in the prioritization process. In addition, the process, the preliminary results and the final report were distributed and presented at council meetings. Further information on the council and their involvement is discussed in section 4.3.

MCH Needs Assessment

Maternal and child health advocates from across the state were used as a baseline to identify priority issues for Iowa's maternal and child population. A survey was distributed to over 180 participants at the 2000 Annual MCH Conference, including FSB grantees and CHSC regional staff. The survey results identified the following as the top three health issues for families: 1) access to dental care, 2) availability of health insurance for dental care, and 3) lack of readiness for parenthood. A complete listing of survey results is included in Appendix L.

HI2010

The five-year needs assessment was completed using the *HI2010* goals as a framework. Approximately 550 Iowans accepted the challenge to advance the boundaries of healthy living and the quality of life as well as to eliminate health disparities in the new decade. These Iowans, representing more than 200 separate organizations, developed *Healthy Iowans 2010*. The document can be considered a product of all the groups contributing to it, with the Iowa Department of Public Health serving as lead agency. These organizations have assumed major roles to assure that the plan is implemented. Goals for the five-year needs assessment were selected out of related Maternal and Child Health *HI2010* chapters for the prioritization process. Hence the process is based on the assumption that goals selected for *HI2010* were chosen because they were a priority for the state.

The Iowa health plan is a companion to the national plan, *Healthy People 2010*. *Healthy People 2010*, a nationwide effort to improve the health of the American people, will drive federal resources allocation for disease prevention and health promotion in the new decade. Iowa's plan has four themes—**empowerment, eliminating health disparities, collaboration, and dynamic change.**

A Healthy Iowans 2010 conference, "Barn Raising II: Communities Building a Healthy Iowa", held June 3-4, 1999, at Drake University, brought together about 700 public health and community leaders for their input into the state plan, and assisted participants in developing local plans. Solutions to health problems occur at the local level. Therefore, state and local plans will provide a blueprint for communities to deal with their identified problems.

Complete chapters of the Iowa plan are available as separate publications. The entire publication can be accessed on http://www.idph.state.ia.us/sa/h_ia2010/contents.htm

Following the *Barnraising II* conference, each of Iowa's counties embarked on development of the Community Health Needs Assessment and Health Improvement Plan (CHNA-HIP). The template provided by the IDPH served as an organizing framework for reporting needs, resources, problems, and actions. Local boards of health convened community partners to participate in the assessment and planning. Each county's plan addressed the following categories of health status indicators:

- Demographic and socio-economic characteristics
- General health and access to care
- Maternal and child health indicators
- Chronic disease

- Infectious disease
- Environmental control
- Injury control, occupational safety, domestic violence and sexual assault
- Substance abuse, tobacco use and problem gambling behaviors

The health improvement plan identified problems, community assets and resources, community barriers, goals, action steps, and evaluation or measurement of progress. Each report summarizes the health problem priorities and community partnerships to address selected health priorities. Reports for individual counties can be accessed on the DPH website www.idph.state.ia.us (double click on "Resources, Publications, Data on Iowa Community Health Needs Assessment Data.")

Results of the CHNA-HIP reports were reviewed by FSB and categorized using keywords. The categories were based on the keywords used by MCHB to organize state reports of needs. Based on this analysis, the three top health issues identified by Iowa counties are: 1) access to services, 2) substance use, and 3) chronic disease. A more complete listing of the results, categorized by key word analysis, is included in Appendix M.

In addition, results of the CHNA-HIP were further applied as the cornerstone of community based planning for development local maternal health, child health, family planning and WIC program planning. The Request for Proposal for the 5-year project period beginning October 1, 2000 requires consideration of related indicators. At this time, applications from community-based MCH agencies are currently under review by IDPH. Updates from this review process will be considered in ongoing needs assessment efforts.

Problem Prioritization Process (applies to all three population groups). Because of the large number of problem areas competing for resources, it was necessary to assign priority to the problems. The method chosen was that suggested by staff of the "Family Health Outcomes Project" centered at the University of California – San Francisco. The prioritization process was adapted from Peoples-Sheps, et. al. and offered as part of an on-line continuing education opportunity offered by the University of California – Berkeley titled, "Using Quantitative Data for MCH Planning: Problem Identification and Analysis."

The first stage of the prioritization process was to assemble a planning group for the purpose of participating in the process. Both the FSB and CHCS used selected state and local Title V staff as participants. In addition, several members of the State MCH Advisory Council performed the prioritization. The second stage of the process was to assemble the pool of problems (sometimes referred to as program goals) to which the prioritization process would be applied. This was done

separately for the population areas of maternal health, child health, and children with special health care needs. The specific steps of the prioritization process are summarized here.

1. Planning group identifies problem areas. – This step was accomplished by selecting from the Maternal, Infant, and Child Health chapter of the *Healthy Iowans 2010* document. A team of nearly 50 MCH service providers and parent representatives wrote this chapter. The 20 chapter goals address an array of widely agreed upon health-related problems encountered by women, children, children with special health care needs, and families. To broaden the pool of considered problems, other chapters in *Healthy Iowans 2010* were reviewed, specifically chapters on Mental Health, Public Health Infrastructure, Disabilities, Access to Services, Family Planning, Immunization, Nutrition, Oral Health, Substance Abuse, Tobacco, and Unintentional Injuries. Also included in the problem pool were the Title V national and state priority needs. Status as a *Healthy Iowans 2010* goal or Title V priority need was felt to be qualification enough to be included in the pool of considered problem areas for this particular prioritization process.

2. Planning group brainstorms and selects criteria to prioritize problems. This step was accomplished using a subset of the planning group with representatives from the participating MCH and CSHCN programs. Criteria were chosen and reviewed for utility in rating the pool of considered problem areas. The criteria ultimately chosen follow:
    - Degree to which goal is reachable by known interventions
    - Degree of health-related consequence of not addressing goal
    - Degree of non-Title V state and national support for addressing goal
    - Degree of current demographic disparity regarding goal
    - Degree to which other local providers or service consumers identify goal as a need

    The criteria are felt to be mostly independent of each other and to address a number of relevant qualities by which a particular problem area might be evaluated for its importance. Although the criteria are eligible for weighting according to agreed upon importance to the prioritization process, in this case all five criteria were weighted equally. A simple three-point scoring scale was used to assess how well each of the considered problems met each of the five criteria.

3. Planning group members individually assign priority scores to all considered problems. A "Health Problem Prioritization Tool (Matrix)" is used to assign criteria-based scores to each of the considered problems. Individual rater scores are totaled to calculate a grand total for each considered problem. The grand totals for each problem are ranked from highest to lowest, highest score equated with highest priority.

4. Planning group finalizes its selection of priority problems. Although the quantitative prioritization process results in an ordinal ranking of problems, the planning group gathers for final discussions before finalizing the selection of priority needs. This step allows for the expression of any previously withheld reservations or newly emerging considerations.

Strengths and Limitations. Strengths of this method lie in its quantitative approach to prioritizing problems or needs, the use of consensus to generate problem lists and ratings criteria, and the equal value given to all participant ratings. Limitations of this method include potential bias due to the incomplete representation of all potential stakeholders in the prioritization process, arbitrary assignment of criteria rating scores (a common experience reported by planning group raters), and reliance on differences in rank order that may be practically insignificant.

Pyramid Levels. The Problem Prioritization Process provided needs-related information for all four pyramid levels. For the FY01 assessment, the pool of problem considerations included problems or goals representing each pyramid level within each population group. The table below presents examples using abbreviated goal statements.

	MATERNAL/INFANT HEALTH	CHILD HEALTH	CSHCN HEALTH
DIRECT CARE SERVICES	Increase delivery of LBW babies at high-risk delivery facilities	Increase dental care treatment services to children	Increase follow-up services for children identified at high-risk
ENABLING SERVICES	Increase breastfeeding rates (via education)	Improve reception of Medicaid services by eligible children	Improve transition and coordination services for adolescent age CSHCN
POP-BASED SERVICES	Prevent STD cases to reduce morbidity and mortality	Increase immunization rates among children 19-35 months	Increase hearing screening for newborns
INFRASTRUCTURE BLDG SERVICES	Increase provider marketing information regarding accessibility	Improve childcare quality via licensing and registration	Modify data system for use in performing core public health functions

FSB Results

The following table represents how the complete pool of Maternal Health and Child Health related goals were ranked by the FSB staff, MCH Advisory Council, and the MCH grantee agencies. A listing of the individual group ranking is shown in Appendix N. The results from the prioritization process were compared and used for the selection of the new state performance measures. Dispositions on the goals are indicated in the last column of the table.

Pool of Problem Areas/Goals for Maternal Health	***Avg Score***	***Total Score***	***Disposition***
Reduce pregnancies in women ages 12-17	13.42	349	NPM
Increase intended pregnancies for women 14-55 yr	11.96	311	HI2010
Reduce infant mortality rate to no more than 5 per 1, 000 live births	12.77	332	NPM
Increase to 90% the proportion women getting prenatal 1st trimester	12.62	328	NPM
Reduce low birth weight to no more than 5%	12.58	327	NPM
Reduce death and illness by preventing STD's	12.15	316	HI2010
Increase to 95% the proportion of LBW infants born at high risk delivery facilities	11.81	306	NPM
Increase to 72% women on Medicaid getting enhanced services	11.62	302	NPM
Prevent HIV transmission and associated morbidity and morality	11.58	301	HI2010
Percent of children being breastfed at discharge	10.46	272	NPM
Increase the number of adults with disabilities providing accessible marketing information	8.65	225	HI2010

Pool of Problem Areas/Goals for Child Health	***Avg Score***	***Total Score***	***Disposition***
Increase immunization levels to 90%	13.39	501	NPM
Reduce vaccine preventable disease by 50%	13.38	500	NPM
Increase insurance coverage for children	13.34	496	NPM
Increase specialty services paid by Medicaid	12.89	490	HI2010
Increase to 70% proportion of children receiving dental care	12.53	476	SPM
Increase the % of children with a medical home	12.53	476	SPM
Reduce untreated cavities in children	12.49	486	HI2010
Increase to 90% children needing and receiving mental health services under Title V or XIX	11.76	447	SPM
Increase the % of children receiving licensed or registered child care	11.58	440	HI2010
Reduce child mortality to 21 per 100,00 in ages 1-14	11.53	451	NPM
Increase to 94% newborns screened for hearing impairment	10.79	410	NPM
Increase use of seat belts to 85%	10.79	410	NPM
Decrease weight gain among children and adolescents	10.5	399	SPM
Reduce MVA deaths to no more than 15.5 per 100,000	10.29	391	NPM

CHSC Results

Eight members of the CSHC Leadership Council ranked the pool of 29 considered problems for the CSHCN population. In addition, four members of the State MCH Advisory participated in a similar prioritization process of the selected goals. The prioritization process functioned as a means to organize systematically and rationally a large number of worthy MCH and CSHCN-related goals. Following is a table indicating how the complete pool of CSHCN-related problems were ranked. Dispositions of the highest ranking problems are indicated in the last column of the table.

Pool of Problem Areas/Goals	***Avg Score***	***Total Score***	***Disposition***
Assure mental health providers are trained in children's mental health	12.9	103	CHSC Level 2
Increase rate of high-risk infants receiving follow-up through 30 months	12.4	99	SPM
Assure CSHCN a source of insurance for primary and specialty care	12.1	97	NPM
Provide/pay for specialty services not otherwise accessible	12	96	NPM
Create a service system for CSHCN as per Public Law 101-239	11.6	93	HI2010
Assure SSI kids receive rehab services if not paid by Title XIX	11	88	NPM
Implement comprehensive system for mental health services	11	88	SPM
Train public health workforce in core public health functions skills	10.6	85	CHSC Level 1
Provide medical/health home for all CSHCN	10.3	82	NPM
Assures family participation in policy and program activities	10.3	82	NPM
Implement adolescent transition strategies to maximize independence	10	80	CHSC Level 1
Encourage use of shared management protocols in Medicaid Mgd Care	9.9	79	SPM
Create a point of State government responsibility for mental health	9.9	79	HI2010
Create a data system for strategic assessment of health of CSHCN	9.6	77	SPM
Encourage general medical providers to use quality improvement	9.5	76	SPM
Use performance standards at local level for public health services	9.4	75	
Create innovative models for delivery of community disability services	9.3	74	
Use summary measures of health and infrastructure at local level	9.3	74	
Improve hearing screening rates for newborns	9.1	73	
Use registered providers to improve child care environment for CSHCN	9.1	73	
Improve school nurse to student ratios to benefit student health services	8.9	71	
Provide collaborative training opportunities for mental health providers	8.9	71	
Strengthen role of families in designing mental health system	8.5	68	
Increase access to easy-to-use methods to analyze public health data	8.5	68	
Promote insurance plan consumer-friendly marketing information	8.4	67	
Disseminate information on public health research to communities	8.4	67	
Increase funding for children's mental health services research	8.4	67	
Develop an in-service and pre-service disabilities curriculum	8.1	65	
Increase standardization and utilization of public health data elements	8.1	65	

key:

CHSC level 1 priority program goal

CHSC level 2 priority program goal

CHSC level 3 priority program goal

CHSC Strategic Direction Assessment Process (applies to the CSHCN population group).

The strategic process was used to supplement the Problem Prioritization Process described above. The specific steps of the process follow.

1. Brainstorming program activities. The entire CHSC Leadership Council, composed of fourteen key regional and central office staff, engaged in a preliminary brainstorming exercise to suggest for consideration any aspect of the program from direct care services through infrastructure building services. In fact, the brainstorming procedure was organized by

pyramid level to assure conscious consideration of all aspects for which the state CSHCN Program is responsible. Nearly 200 separate and highly specific program activities were listed for consideration.

2. Factoring the list of program activities. The listing of all program activities was followed by a factoring exercise where all the activities were clustered within 18 conceptually discrete program areas. It was understood that each program area was congruent with the CHSC mission – *"to improve the health, development, and well-being of children and youth with special health care needs in partnership with families, service providers, and communities"* – and was in need of varying degree of improvement.
3. Multi-voting procedure to prioritize program areas. The next step was to use a two-stage multi-voting process to prioritize the programmatic areas. Each member of the Leadership Council was permitted to vote for the ten CHSC program areas they felt to be most essential to meeting the needs of Iowa's CSHCN population. This process was repeated to distill the priority list to five program areas.
4. Follow-up group discussion to finalize priority areas. There was substantial group discussion following the voting procedure. Additional logistical and system context factors were considered and this resulted in some modification of the vote-determined priority order. It was evident that a prominent area of consideration was the general involvement and interest of other national, state, and local providers in all of the program areas. Usefulness of collaborating, readiness to move forward, and available resources compared to expense estimates were all instrumental in finalizing the priorities.

Strengths and Limitations. The strengths of the Strategic Direction Assessment Process include its participatory ground rules and its combination of quantitative and qualitative strategies to determine priorities. Its major limitation is the lack of any family involvement in the process. This fault reaffirms the importance of increasing family program participation as a level one (highest) priority.

Pyramid Levels. The Strategic Direction Assessment Process addressed all levels of the pyramid as described above in the first step of the process. There was no rule stating that the final chosen highest priorities had to represent all pyramid levels; however, this turned out to be the case.

Results. Program areas within priority levels are listed alphabetically. Note that there are no within level priority assignments.

PROGRAM AREAS RECEIVING LEVEL 1 PRIORITY RATING (pyramid levels represented are included in parentheses)
Care coordination services (enabling)
Data system development (infrastructure building)
Early childhood (at-risk) follow-up (population-based)
Mobile clinic services review (direct care)
Family program participation (enabling, infrastructure building)
Staff training and development (infrastructure building)
PROGRAM AREAS RECEIVING LEVEL 2 PRIORITY RATING
Child care services for CSHCN (enabling, infrastructure building)
Mental health services for CSHCN (direct care)
Regional clinic services review (direct care)
Telehealth services (direct care)
PROGRAM AREAS RECEIVING LEVEL 3 PRIORITY RATING
Genetic services for CSHCN (enabling)
Health education for families (enabling)
Insurance access (enabling, infrastructure building)
Marketing and promotion (infrastructure building)
Nutrition services for CSHCN (direct care, enabling)
Research participation and contribution (infrastructure building)
Screening activities (population-based)
Transition services for CSHCN (enabling, infrastructure building)

The six program areas that qualified as first level priorities are currently being addressed through the formation of six CHSC "Strategic Initiative Teams". These teams will each do further needs assessment, problem analysis, action step formulation, and timeline setting. Two of the first level priority program areas are also represented as Title V performance measures – Family Program Participation (NPM #14) and Early Childhood Follow-up (SPM #5).

Family Needs and Satisfaction Survey (applies to the CSHCN population group). This survey was completed in FFY97, but it supplies information relevant to the upcoming five-year planning cycle. A mail out questionnaire was developed with assistance from the University of Iowa Social Science Institute. Simplicity, brevity, and codable responses were priorities in questionnaire development. Responses were mostly forced-choice. Questions pertaining to family satisfaction used a Likert rating scale followed by opportunities for open-ended elaboration. Areas of inquiry included:

- demographics (child's age; and responder's county of residence, relationship to child, race/ethnicity, education, and income);
- duration receiving services;
- condition severity (specific condition diagnoses were not requested);
- satisfaction with overall community health and school health services;

- need for and satisfaction with an array of community support services; and
- use of care coordination services.

The open-ended responses provided opportunity to explain reasons for dissatisfaction with health and community support services.

Questionnaires were distributed to two groups. The first group (referred to as the CHSC group) was all families who used CHSC clinic services during a three-month interval in the Spring of 1995. The 979 questionnaires were distributed at the clinic sites for Integrated Evaluation and Planning Clinics (IEPC) and through the mail for all other clinic attendees (Cardiac, Orthopaedic, Child Consultation, Ear-Nose-Throat, Endocrine, Muscle Disorder, Cystic Fibrosis, Pediatric Rheumatology, Down Syndrome, and Cleft Lip/Palate). Questionnaires were completed anonymously. A reminder postcard was sent to all questionnaire recipients 2-3 weeks after initial receipt of the questionnaire. The response rate for the CHSC group was 44% (429/979).

The second group of questionnaire recipients (referred to as the SSI group) comprised families who were accepted into the Supplemental Security Income program (SSI), but were not current or past users of CHSC services. This group was chosen because it represented children with special health care needs whose parents would not feel predisposed to favorable questionnaire responses due to utilization of CHSC services. Also, by definition, families accepted into the SSI program are low income, representing a demographic group of high interest in a needs assessment. The source of names for this group is the Disability Determination Services Bureau within the Department of Education. The response rate for the SSI group was 30% (177/590). Response frequencies from the CHSC and SSI groups were compared for all the variables listed above.

After comparing the CHSC and SSI groups, they were pooled and resegregated according to urban and rural counties of residence. This was reasonable because the proportion of respondents residing in urban and rural counties was similar in the CHSC and SSI groups. There were 422 urban responders and 149 rural responders. Using a variable with only two values – urban or rural – allowed sample sizes sufficient for comparison. The underlying assumption is that urban and rural counties, regardless of where they occur in the state, share similarities with other urban and rural counties.

The relationship between the severity of a child's condition and satisfaction with overall community health services was of interest. To investigate this relationship, a "severity index" variable was

created. The distribution of index scores was heavily weighted toward the mild group (440 of 606 total respondents), so the moderate and severe groups were combined and labeled severe.

Survey Questions and Values Used to Calculate the Severity Index		
Q.1: In general, how would you describe your child's health?		
	Excellent or Good	1
	Fair	2
	Poor	3
Q.6: For how many days was your child in bed in the past 12 months due to his/her condition?		
	0-4 days	1
	5-10 days	2
	>10 days	3
Q.8: For how many days was your child in the hospital during the past 12 months?		
	0 days	1
	1-4 days	2
	>4 days	3
Q.15: For how many days was your child absent from school due to his/her condition in the past 12 months?		
	1-4 days	1
	5-10 days	2
	>10 days	3
Severity Index Range = 4-12 (where 4 is mild; 5-8 is moderate; and 9-12 is severe)		

Also tested was the relationship between length of time the child has received services and satisfaction with overall community health services.

Response frequencies and chi-square tests for independence were calculated using the statistical functions of Microsoft Excel. Groups whose responses were compared across selected variables were: 1) the CHSC group and SSI group, and 2) the Urban group and Rural group. Statistically significant difference between groups was assumed to occur at a probability level of .05 ("p value"). Open-ended responses were collected and categorized by consensus of the project staff.

Strengths and Limitations. The strength of this study is the relatively large number of respondents and the consequent ability to statistically compare different subgroups (CHSC and SSI; Urban and Rural) on a number of different demographic, health status, and health care utilization variables. Also, the open-ended responses lend some personal testimony to the overall assessment of family need. The limitation of this study is the responder bias that may have occurred due to a possible difference between responders and nonresponders. Also, a possible sampling bias means that it is not certain that the responders are representative of all families who have children with special health care needs. Finally, all statistics were univariate analyses, which are less able to explain complex relationships that multivariate analyses.

Pyramid Levels. The study, although of value in the assessment process as an infrastructure building activity, was itself an investigation of family needs for and experiences with direct care and enabling services. Findings were associations between family satisfaction with direct care and enabling services and various demographic, health status, and health service utilization variables. The study also compared different groups of families of CSHCN on need and satisfaction variables.

Results.

COMPARISON BETWEEN THE CHSC AND SSI GROUPS

Table 1 presents age-related data for the CHSC and SSI groups. The mean current age of CHSC children was greater than that for SSI children (8.2 years old vs. 6.8 years old). The mean age at first service for the child's chronic condition was greater for the CHSC children (4.4 years old vs. 3.8 years old). The mean duration of time receiving services (the difference between the mean current age and the mean age at first service for the chronic condition) was again greater for the CHSC group (3.8 years vs. 3.1 years).

TABLE 1

AGE OF CHILD			
Age	**Total Group**	**CHSC Subgroup**	**SSI Subgroup**
0-1 years	62 (10%)	43 (10%)	19 (11%)
2-5 years	165 (28%)	100 (24%)	65 (37%)
6-10 years	202 (33%)	153 (36%)	49 (28%)
11-15 years	137 (23%)	99 (23%)	38 (21%)
16+ years	37 (6%)	31 (7%)	6 (3%)
TOTAL	**603 (100%)**	**426 (100%)**	**177 (100%)**
MEAN AGE	**7.8 years**	**8.2 years**	**6.8 years**
AGE AT FIRST SERVICE			
0-1 years	237 (39%)	162 (38%)	75 (42%)
2-5 years	173 (29%)	118 (27%)	55 (31%)
6-10 years	128 (21%)	97 (23%)	31 (18%)
11-15 years	63 (10%)	47 (11%)	16 (9%)
16+ years	5 (1%)	5 (1%)	0 (0%)
TOTAL	**606 (100%)**	**429 (100%)**	**177 (100%)**
MEAN AGE	**4.3 years**	**4.4 years**	**3.8 years**
DURATION OF SERVICE (= current age–age at first service)			
MEAN DURATION	**3.5 years**	**3.8 years**	**3.0 years**

Table 2 presents comparisons between the CHSC and SSI groups for a number of demographic variables. Statistically significant differences are noted for race (higher percentage of minority respondents on SSI), education (less years of education completed by SSI respondents), and pretax annual household income (lower annual income for SSI respondents). Of interest, the request for income information was granted by 410 of 429 CHSC respondents (96%) and 166 of 177 SSI respondents (94%). Also, there was not a statistically significant difference between the proportions of CHSC and SSI respondents living in urban versus rural counties.

TABLE 2

SELECTED DEMOGRAPHIC VARIABLES (CHSC and SSI Subgroups)			
Race	**Total Group**	**CHSC Subgroup**	**SSI Subgroup**
White	567 (95%)	411 (97%)	156 (92%)
African American	12 (2%)	3 (<1%)	9 (5%)
Hispanic	4 (<1%)	4 (<1%)	0 (0%)
Native American	4 (<1%)	2 (<1%)	2 (1%)
Asian/Pacific Islander	4 (<1%)	3 (<1%)	1 (1%)
Others	4 (<1%)	2 (<1%)	2 (1%)
TOTAL	**595 (100%)**	**425 (100%)**	**170 (100%)**
Highest Grade Completed			
< High School	47 (8%)	25 (6%)	22 (13%)
Finished High School	182 (31%)	127 (30%)	55 (32%)
Vocational Training	235 (39%)	164 (38%)	71 (42%)
Bachelor's Degree	58 (10%)	50 (12%)	8 (5%)
Some Graduate School	24 (4%)	18 (5%)	6 (3%)
Graduate Degree	48 (8%)	39 (9%)	9 (5%)
TOTAL	**594 (100%)**	**423 (100%)**	**171 (100%)**
Household Income (1994)			
$0-14,999	166 (29%)	101 (25%)	65 (39%)
$15,000-22,999	120 (21%)	67 (16%)	53 (32%)
$23,000-30,999	110 (19%)	85 (21%)	25 (15%)
$31,000-38,999	66 (11%)	58 (14%)	8 (5%)
$39,000-45,999	35 (6%)	30 (7%)	5 (3%)
$46,000-53,999	32 (6%)	30 (7%)	2 (1%)

$54,000 or above	47 (8%)	39 (10%)	8 (5%)
TOTAL	**576 (100%)**	**410 (100%)**	**166 (100%)**
Place of Residence			
Urban County	422 (74%)	291 (73%)	131 (77%)
Rural County	149 (26%)	110 (27%)	39 (23%)
TOTAL	**571 (100%)**	**401 (100%)**	**170 (100%)**

Child's condition severity using the severity index was compared between the CHSC and SSI groups. Table 3 shows that this difference was highly significant with the SSI respondents reporting a higher proportion of severely affected children (47% of SSI group versus 19% of CHSC group). Although not a variable used in constructing the severity index, the child's ability to perform usual age appropriate activities was significantly less in the SSI group versus the CHSC group (27% of the SSI group versus 72% of the CHSC group).

TABLE 3

SEVERITY OF CHILD'S CONDITION			
Severity (Index Value)	**Total Group**	**CHSC Subgroup**	**SSI Subgroup**
Mild (4)	440 (73%)	347 (81%)	93 (53%)
Moderate/Severe (5-12)	166 (27%)	82 (19%)	84 (47%)
TOTAL	**606 (100%)**	**429 (100%)**	**177 (100%)**

Table 4 shows the greater reported use of pediatricians and pediatric specialists by the SSI group, although family practitioners are most prevalently used by both groups.

TABLE 4

THE CHILD'S PROVIDERS OF HEALTH CARE IN THE COMMUNITY (CHSC and SSI Subgroups)			
Provider Type	**Total Group**	**CHSC Subgroup**	**SSI Subgroup**
Family Practitioner	419 (69%)	316 (74%)	103 (58%)
Pediatrician	180 (30%)	116 (27 %)	64 (36%)
Pediatric Specialist	68 (11%)	30 (7%)	38 (21%)
Other Specialist	27 (4%)	17 (4%)	10 (6%)
Hospital ER Physician	101 (17%)	67 (16%)	34 (19%)
School Nurse	91 (15%)	63 (15%)	28 (16%)
Visiting Nurse (VNA)	16 (3%)	6 (2%)	10 (6%)
Public Health Center	36 (6%)	26 (6%)	10 (6%)
Other	55 (9%)	23 (5%)	32 (18%)

TOTAL RESPONDENTS (>1 response permissible)	**606**	**429**	**177**

Table 5 presents a comparison of CHSC and SSI groups regarding use of someone to help organize health and related services. We assumed this simply phrased question reflects the essence of the more technical term, "care coordination." The SSI group reported a statistically significant greater use of help than the CHSC group (33% versus 17%). Furthermore, if respondents who self-organize services are added to those who use outside help, the proportions remain significantly different and increase to 80% of SSI respondents and 58% of CHSC respondents.

TABLE 5

DO YOU USE HELP ORGANIZING HEALTH CARE AND OTHER SERVICES? (CHSC and SSI Subgroups)			
	Total Group	**CHSC Subgroup**	**SSI Subgroup**
Yes, Help is Used to Organize Care	124 (21%)	67 (17%)	57 (33%)
No, I Organize the Care	249 (43%)	168 (41 %)	81 (47%)
No, Care Does Not Need to be Organized	206 (36%)	171 (42%)	35 (20%)
TOTAL	**579 (100%)**	**406 (100%)**	**173 (100%)**
WHO HELPS ORGANIZE HEALTH CARE AND OTHER SERVICES?			
Family Member	20 (18%)	14 (21%)	6 (11%)
Friend	4 (3%)	2 (3%)	2 (3%)
Professional Provider	80 (63%)	42 (63%)	38 (67%)
Other	20 (16%)	9 (13%)	11 (19%)
TOTAL	**124 (100%)**	**67 (100%)**	**57 (100%)**

COMPARISON BETWEEN THE URBAN AND RURAL GROUPS

Recall that the CHSC and SSI subgroups were pooled and then redistributed according to residence in an urban or rural county. Of the total sample of 606 respondents, 422 reported living in an urban county, 149 in a rural county, and 35 did not answer this question. Table 6 presents comparisons between the Urban and Rural subgroups for education and annual household income. There were no statistically significant differences.

TABLE 6

SELECTED DEMOGRAPHIC VARIABLES (Urban and Rural Subgroups)			
Highest Grade Completed	**Total Group**	**Urban Subgroup**	**Rural Subgroup**
< High School	41(7%)	28 (7%)	13 (9%)
Finished High School	175 (31%)	132 (31%)	43 (29%)
Vocational Training	229 (41%)	165 (39%)	64 (43%)
Bachelor's Degree	52 (9%)	40 (10%)	12 (8%)
Some Graduate School	23 (4%)	18 (4%)	5 (3%)
Graduate Degree	47 (8%)	36 (9%)	11 (8%)
TOTAL	**567 (100%)**	**419 (100%)**	**148 (100%)**
Household Income (1994)			
$0-14,999	158 (29%)	118 (29%)	40 (27%)
$15,000-22,999	119 (22%)	79 (20%)	40 (27%)
$23,000-30,999	101 (18%)	78 (19%)	23 (16%)
$31,000-38,999	62 (11%)	45 (11%)	17 (12%)
$39,000-45,999	35 (6%)	24 (6%)	11 (8%)
$46,000-53,999	30 (6%)	20 (5%)	10 (7%)
$54,000 or above	45 (8%)	40 (10%)	5 (3%)
TOTAL	**550 (100%)**	**404 (100%)**	**146 (100%)**

The relationship between severity of the child's condition and residence in an urban or rural county was tested for each of the 4 severity index variables. None of the tests approached statistical significance suggesting no association between condition severity and urban-rural residence.

Table 7 shows a higher proportion of the Urban group reporting use of pediatricians, although family practitioners are the most prevalently used physicians by both groups.

TABLE 7

THE CHILD'S PROVIDERS OF HEALTH CARE IN THE COMMUNITY (Urban and Rural Subgroups)			
Provider Type	**Total Group**	**Urban Subgroup**	**Rural Subgroup**
Family Practitioner	399 (45%)	269 (64%)	130 (87%)
Pediatrician	167 (19%)	148 (35%)	19 (13%)
Pediatric Specialist	65 (7%)	46 (11%)	19 (13%)
Other Specialist	26 (3%)	18 (4%)	8 (5%)
Hospital ER Physician	94 (11%)	74 (18%)	20 (13%)
School Nurse	86 (10%)	57 (14%)	29 (19%)
Visiting Nurse (VNA)	15 (2%)	13 (3%)	2 (1%)
Public Health Center	34 (4%)	24 (6%)	10 (7%)
TOTAL RESPONDENTS (>1 response permissible)	**886**	**649**	**237**

Table 8 shows there was no significant difference between Urban and Rural groups in the use of someone to help with care coordination. Specifically, 22% of both urban and rural respondents reported using a helper to organize services. When adding in respondents who self-organize, the proportions in both groups increase, but remain similar at 43% of urban respondents and 39% of rural respondents.

TABLE 8

DO YOU USE HELP ORGANIZING HEALTH CARE AND OTHER SERVICES? (Urban and Rural Subgroups)			
	Total Group	**Urban Subgroup**	**Rural Subgroup**
Yes, Help is Used to Organize Care	118	88 (22%)	30 (22%)
No, I Organize the Care	232	176 (43%)	56 (39%)
No, Care Does Not Need to be Organized	199	143 (35%)	56 (39%)
TOTAL	**549 (100%)**	**407 (100%)**	**142 (100%)**

SATISFACTION WITH HEALTH CARE SERVICES

Respondents were asked to rate their general satisfaction with the health care provided for their child. Table 9 presents the distribution of Likert Scale responses for the CHSC vs. SSI groups, and the Urban vs. Rural groups. A statistically significant difference ($p \leq .05$) in satisfaction was found between the CHSC and SSI groups with the SSI group reporting less satisfaction. No difference was found between the Urban and Rural groups.

TABLE 9

SATISFACTION WITH HEALTH CARE SERVICES						
	CHSC and SSI Subgroups			**Urban and Rural Subgroups**		
Level of Satisfaction	**Total Group**	**CHSC Subgrp**	**SSI Subgrp**	**Total Group**	**Urban Subgrp**	**Rural Subgrp**

1 = very low	9 (2%)	4 (1%)	5 (3%)	10 (2%)	7 (2%)	3 (2%)
2	25 (4%)	14 (3%)	11 (6%)	22 (4%)	18 (4%)	4 (3%)
3	87 (15%)	46 (11%)	41 (24%)	82 (15%)	61 (15%)	21 (14%)
4	231 (39%)	172 (41%)	59 (35%)	221 (39%)	159 (38%)	62 (43%)
5 = very high	239 (40%)	185 (44%)	54 (32%)	224 (40%)	168 (41%)	56 (38%)
TOTAL	**591 (100%)**	**421 (100%)**	**170 (100%)**	**559 (100%)**	**413 (100%)**	**146 (100%)**

Table 10 presents a summary of open-ended responses given by the CHSC and SSI subgroups for dissatisfaction with health care services. Allowing that any one respondent could give more than one reason for dissatisfaction, there were 88 reasons from 71 respondents in the CHSC subgroup and 77 reasons from 56 respondents in the SSI subgroup.

TABLE 10

Reason for Dissatisfaction with Health Care Services	*# of Reasons (CHSC Subgroup)*	*# of Reasons (SSI Subgroup)*	*Response Examples*
Providers and support services not sufficiently available	8	2	"we need more specialized care for his condition" "she has needed PT and none available" "very poor county – services are few and usually distant"
Providers too busy / no patience	6	7	"child very hard to examine and doctors don't like to spend a lot of time" "doctors seem to be in such a rush these days – not enough quality time" "sometimes they don't seem to have patience enough for my daughter's condition" "I am displeased with our local pediatricians – they are very money hungry I feel and give poor service – we feel very rushed and not cared for very well"
Providers incompetent / not thorough	17	11	"our child tends to have prolonged seizures and we still find people in the ER who don't know how to address that properly" "I don't think her doctor knows that much about asthma and I don't think he knows she has it as bad as she does" "some doctors do not understand disability or treat him with the respect that is due" "my current pediatrician does not seem to pay attention to the information sent to his office from other sources"
Providers communicate poorly / too quiet	5	8	"our family physician is a quiet person, so sometimes it's hard to talk to him" "I feel more could be told as what to expect – what more to do now" "not having anything explained in detail" "I sometimes feel there's something going on with my son more than they're saying"

Providers do not consider parents' views and circumstances	9	6	"we've had a hard time convincing doctors that he had problems" "doctors treat me like I'm stupid and treat my child's illnesses only when so severe that he misses a lot of school" "the main problem I have is none of the health care people seem to take what I'm saying seriously" "some health professionals don't seem to consider my opinions or observations of any importance"
Not the same providers for each visit	3	1	"would like to stay with the same doctor or 2 or 3 each time instead of having a different one each clinic visit" "it is seldom the same doctor that sees our son"
Service is disorganized / slow / a bureaucratic hassle	9	5	"we always have to wait too long and I'm trying to make child leave people alone" "slow in receiving results" "the hospital was disorganized, confusing"
Treatment not up to expectations (includes undertreatment and overtreatment	15	16	"need someone that can work with her so she isn't afraid and gets a better exam" "we get a little frustrated with tests being constantly ordered because our daughter is in a high-risk category – it's hard to sort out which expensive tests are truly necessary" "it seems that we have to wait until a child is in really bad shape before care is made available – earlier intervention would be so much better" "I'm not sure that the quality of service we receive in _____ is all that good" "some of the doctors would not admit she had a problem at first" "no one wants to do their job"
Inconsistent or uncertain diagnosis / treatment	2	5	"they can't find a reason why she has had a runny nose for 3 months and they all disagree on the treatment of her" "doc's don't all have the same story" "no one knows a diagnosis and he's not getting better"
High cost / inadequate insurance	4	7	"cost is still prohibitive for those without insurance and not eligible for Medicaid" "the cost of office visits is up to $31 – even with insurance, medical care is expensive" "in Iowa City, her health insurance Title XIX didn't allow her to stay to have all tests she needed"
Transportation problem / large distance / inconvenient hours	4	4	"miles to go to see a specialist" "hours not always convenient"
Other (including unfriendly or disrespectful provider)	6	5	"I feel there is always room for improvement in the fast pace of the health care field" "some of the nurses weren't all that nice" "some doctors do not understand disability or treat him with the respect that is due" "I wish he could get his treatment closer to home, but he will not communicate to or with the doctors here"

The entire pooled respondent group was used to test the association between satisfaction with health care services and duration of time receiving services. There was no statistically significant association. However, when the lowest three satisfaction ratings were pooled based on the assumption that any rating of 3 or below reflects a lack of satisfaction, the association nearly reached significance (p=.07). This suggests that families who have received health care services for a shorter length of time may be less satisfied with those services. Table 11 shows the frequency distribution of responses using pooled satisfaction ratings.

TABLE 11

RELATIONSHIP BETWEEN SATISFACTION AND DURATION RECEIVING SERVICES				
Level of Satisfaction	**<1 Year**	**1-2 Years**	**3-5 Years**	**>5 Years**
1-3 = very low	29 (22%)	55 (26%)	20 (19%)	18 (13%)
4	45 (33%)	78 (37%)	44 (41%)	65 (46 %)
5 = very high	60 (45%)	78 (37%)	42 (40%)	57 (41%)
TOTAL	**134 (100%)**	**211 (100%)**	**106 (100%)**	**140 (100%)**

The entire pooled respondent group was also used to test the association between satisfaction with health care services and severity of condition. Table 12 shows the frequency distribution of responses. There was no statistically significant association at the $p \leq .05$ level; however, the association was significant at the p=.09 level, which suggests that families with more severely affected children may possibly be less satisfied with their health care services. This weak association in the pooled sample is not found within the SSI subgroup or the CHSC subgroup alone, although, as shown in Table 3 above, the SSI subgroup is more severely affected than the CHSC subgroup.

TABLE 12

RELATIONSHIP BETWEEN SATISFACTION WITH HEALTH CARE AND SEVERITY OF CONDITION		
Level of Satisfaction	**Mild Condition (by index value)**	**Severe Condition (by index value)**
1 = very low	9 (2%)	1 (0%)
2	14 (3%)	10 (6%)
3	57 (13%)	31 (20%)
4	172 (40%)	60 (38%)
5 = very high	180 (42%)	57 (36%)
TOTAL	**432 (100%)**	**159 (100%)**

SATISFACTION WITH SCHOOL HEALTH SERVICES

The above subgroups were also compared on their satisfaction with school health services for their child. Table 13 shows these satisfaction responses are given on the background of relatively small percentages of students reported to need either special physical accommodations (except for special transportation) or special health procedures to attend school. Table 14 presents the Likert Scale distribution for the four sample subgroups. There are no statistically significant differences; however, there is some suggestion (p=.09) that the Rural subgroup was less satisfied with school health services than their Urban counterparts.

TABLE 13

SPECIAL SERVICES NEEDED IN SCHOOL (number in sample reporting child's attendance at school or day care=550)			
Special Accomodations		**Special Procedures**	
Special Transportation	83 (15%)	**Tube Feeding**	2 (<1%)
Ramps	12 (2%)	**Tracheostomy**	0 (0%)
Other Wheelchair Access	11 (2%)	**Supplemental Oxygen**	2 (<1%)
Water Fountain Access	37 (7%)	**Ventilator Assistance**	4 (<1%)
Special Restroom	16 (3%)	**Catheter Care**	0 (0%)
Elevator	10 (2%)	**Other**	6 (1%)
Other	11 (2%)		

TABLE 14

SATISFACTION WITH SCHOOL HEALTH SERVICES						
	CHSC and SSI Subgroups			**Urban and Rural Subgroups**		
Level of Satisfaction	**Total Group**	**CHSC Subgrp**	**SSI Subgrp**	**Total Group**	**Urban Subgrp**	**Rural Subgrp**
1 = very low	13 (3%)	9 (3%)	4 (3%)	12 (3%)	7 (2%)	5 (4%)
2	20 (4%)	11 (3%)	9 (7%)	18 (4%)	14 (4%)	4 (3%)
3	82 (17%)	52 (16%)	30 (22%)	80 (18%)	49 (16%)	31 (26%)
4	162 (35%)	115 (34%)	47 (35%)	152 (35%)	115 (36%)	37 (30%)
5 = very high	191 (41%)	146 (44%)	45 (33%)	178 (40%)	133 (42%)	45 (37%)
TOTAL	**468 (100%)**	**333 (100%)**	**135 (100%)**	**440 (100%)**	**318 (100%)**	**122 (100%)**

Table 15 presents a summary of open-ended responses given by the CHSC and SSI subgroups for dissatisfaction with school health services. Allowing that any one respondent could give more than one reason for dissatisfaction, there were 38 reasons from 32 respondents in the CHSC subgroup and 34 reasons from 22 respondents in the SSI subgroup.

TABLE 15

Reason for Dissatisfaction with School Health Services	*# of Reasons (CHSC Subgroup)*	*# of Reasons (SSI Subgroup)*	*Response Examples*
No school nurse or only part-time school nurse	10	3	"school nurse is only there part-time and then has to go to another school" "no school nurse; secretary does the job" "the school doesn't have a school nurse; the teachers or principal provides the service" "the nurse is nice person, but only part-time"
School nurse not qualified	2	4	"our school nurse is very limited in her knowledge; this is an unfortunate situation" "school nurse is not very knowledgeable; her only duty is to find parents so she can send children home" "school nurse does not seem to be qualified"
No or not enough individual attention given to child	1	2	"too large of a group so very little attention to her individual needs" "he needs more one-on-one"

Poor communication with parents	2	3	"they don't always inform me when he's had an accident at school, or when he's being really 'droopy'" "don't notify as her medication is needed" "the school and AEA work good together but don't listen to me, the mother, or the lady that works with health at school"
School doesn't care / ignores health recommendations or plans	5	3	"seems not to care about things or needs" "when concerns come up at school and I'm called and asked to call doctor or Iowa City, I do; then they don't take the advice they give" "since the evaluation at the clinic, I have received no feedback from the school; I let the vice-principal know of the results, however I got nothing from him at all; I felt there was no concern or caring at all" "the school seems to think that he should go elsewhere for schooling"
School provides inappropriate treatment	2	0	"it has taken all year to find out she has a learning disability, not ADD as AEA had diagnosed; they had her on Ritalin before they could test her" "they love to medicate a child to calm them down; I don't know if this is always needed"
School doesn't meet special health needs or accommodations	12	7	"school nurses are limited by guidelines they are to follow to provide health services, which are appropriate to an extent" "I feel she does not get the exercise she needs" "they will not distribute medication" "when he was on crutches in May he had to still use the stairs – no other way to classes on second floor" "due to his taking medicine and the fact that they do not make sure he takes it even though they have control of his medicine"
Other (includes school not meeting special education needs)	4	12	"one of the school nurses is very, very mean, crabby and intolerable;…and insensitive to special needs" "sometimes I think he should be in his special class with its limited quantity of children for all subjects during the day" "he's not getting the time in school he needs" "at a daycare home when your child is ill you can't always bring them" "needs more peer assessment and help socially"

The entire pooled respondent group was used to test the association between satisfaction with school health services and severity of condition. Table 16 shows the frequency distribution of responses. A statistically significant association ($p \leq .05$) suggests that families with more severely affected children may be less satisfied with their children's school health services.

TABLE 16

RELATIONSHIP BETWEEN SATISFACTION WITH SCHOOL HEALTH SERVICES AND CONDITION SEVERITY		
Level of Satisfaction	**Mild Condition (by index value)**	**Severe Condition (by index value)**
1 = very low	7 (2%)	6 (5%)
2	10 (3%)	10 (8%)
3	58 (17%)	24 (19%)
4	117 (34%)	45 (36%0
5 = very high	150 (44%)	41 (32%)
TOTAL	**342 (100%)**	**126 (100%)**

OTHER COMMUNITY SUPPORT SERVICES

Table 17 presents a comparison of the CHSC and SSI subgroups, as well as the Urban and Rural subgroups, with respect to an array of community support services likely to be of use to a family having a child with special health care needs. In reviewing these results, keep in mind that the opportunity to respond to questions of satisfaction with services depends on a series of positive responses to prior questions regarding service need, availability, and usage. Hence, if the response to any of the yes-no questions regarding service need, availability, or use was "no", then the question regarding satisfaction is moot.

TABLE 17

NEED FOR SELECTED COMMUNITY SUPPORT SERVICES						
	CHSC Subgroup	**SSI Subgroup**	**"Ö" Means Subgroups Different at (p<.05)**	**Urban Subgroup**	**Rural Subgroup**	**"Ö" Means Subgroups Different at (p<.05)**
Respite Care	29 (8%)	45 (30%)	√	49 (14%)	19 (15%)	
Parent Networking	74 (20%)	53 (36%)	√	71 (20%)	35 (28%)	
Transportation	38 (10%)	48 (30%)	√	61 (16%)	19 (15%)	
Cash Assistance	71 (19%)	86 (55%)	√	116 (32%)	32 (24%)	
Day Care	86 (23%)	46 (29%)		92 (25%)	32 (24%)	
Mental Health Counseling	70 (19%)	68 (43%)	√	97 (26%)	34 (26%)	
Vocational Counseling	24 (7%)	35 (23%)	√	44 (12%)	12 (9%)	
Legal Services	32 (9%)	34 (22%)	√	46 (12%)	19 (15%)	
Financial Counseling	29 (8%)	28 (18%)	√	39 (10%)	16 (12%)	
Trade & Technical Training	32 (9%)	25 (16%)	√	40 (11%)	15 (12%)	
Social Support Group	36 (10%)	28 (18%)	√	47 (13%)	14 (11%)	
Personal Attendant	11 (3%)	14 (9%)	√	17 (5%)	8 (6%)	
Home Care Services	28 (8%)	33 (21%)	√	48 (13%)	12 (9%)	
Recreational Services	63 (17%)	44 (29%)	√	76 (21%)	26 (20%)	
AVAILABILITY OF SELECTED COMMUNITY SUPPORT SERVICES (responders to this question were affirmative regarding "need" for services)						
Respite Care	23 (89%)	33 (79%)		43 (88%)	13 (68%)	
Parent Networking	43 (63%)	19 (46%)		43 (61%)	14 (45%)	
Transportation	31 (86%)	36 (82%)		47 (82%)	17 (89%)	
Cash Assistance	49 (79%)	61 (80%)		81 (80%)	26 (90%)	
Day Care	71 (88%)	27 (61%)	√	68 (78%)	23 (74%)	
Mental Health Counseling	58 (87%)	53 (93%)		81 (92%)	26 (84%)	
Vocational Counseling	18 (86%)	23 (77%)		34 (83%)	5 (63%)	
Legal Services	21 (72%)	22 (73%)		28 (70%)	14 (78%)	
Financial Counseling	18 (75%)	11 (52%)		20 (69%)	7 (50%)	

Trade & Technical Training	20 (80%)	12 (60%)		21 (68%)	10 (77%)
Social Support Group	15 (48%)	8 (44%)		18 (47%)	5 (50%)
Personal Attendant	7 (88%)	9 (82%)		9 (82%)	7 (88%)
Home Care Services	23 (89%)	30 (94%)		42 (91%)	11 (92%)
Recreational Services	36 (67%)	21 (55%)		38 (60%)	14 (58%)

USE OF SELECTED COMMUNITY SUPPORT SERVICES
(responders to this question were affirmative regarding "need" for and "availability" of services

Respite Care	17 (74%)	16 (53%)		26 (65%)	7 (54%)
Parent Networking	31 (74%)	15 (88%)		35 (83%)	8 (67%)
Transportation	28 (93%)	33 (97%)		43 (93%)	16 (100%)
Cash Assistance	44 (92%)	55 (90%)		76 (94%)	22 (88%)
Day Care	61 (92%)	19 (76%)	√	57 (89%)	18 (86%)
Mental Health Counseling	42 (75%)	40 (76%)		60 (75%)	19 (76%)
Vocational Counseling	11 (65%)	13 (59%)		20 (61%)	2 (50%)
Legal Services	16 (76%)	15 (71%)		19 (70%)	12 (86%)
Financial Counseling	11 (61%)	2 (20%)	√	9 (47%)	3 (43%)
Trade & Technical Training	13 (65%)	4 (40%)		8 (42%)	8 (80%)
Social Support Group	7 (50%)	3 (38%)		8 (44%)	2 (50%)
Personal Attendant	6 (86%)	7 (88%)		8 (89%)	5 (83%)
Home Care Services	18 (78%)	24 (86%)		31 (78%)	11 (100%)
Recreational Services	27 (79%)	11 (58%)		23 (64%)	11 (92%)

SATISFACTION WITH SELECTED COMMUNITY SUPPORT SERVICES
(responders to this question were affirmative regarding "need" for, "availability" of, and "use" of services)

Respite Care	15 (94%)	15 (94%)	23 (92%)	7 (100%)
Parent Networking	28 (97%)	13 (87%)	30 (100%)	8 (100%)
Transportation	24 (96%)	27 (90%)	34 (92%)	15 (100%)
Cash Assistance	35 (85%)	41 (76%)	58 (89%)	18 (82%)
Day Care	56 (93%)	17 (90%)	52 (98%)	16 (89%)
Mental Health Counseling	31 (86%)	32 (91%)	45 (90%)	16 (84%)
Vocational Counseling	11 (100%)	11 (85%)	18 (100%)	2 (100%)
Legal Services	12 (86%)	11 (73%)	13 (87%)	10 (83%)
Financial Counseling	9 (82%)	2 (100%)	8 (89%)	2 (67%)
Trade & Technical Training	9 (75%)	4 (100%)	6 (75%)	6 (75%)
Social Support Group	5 (83%)	3 (100%)	6 (86%)	2 (100%)
Personal Attendant	6 (100%)	5 (71%)	6 (100%)	5 (100%)
Home Care Services	18 (100%)	22 (92%)	30 (100%)	10 (91%)
Recreational Services	24 (89%)	10 (100%)	20 (91%)	10 (91%)

Service Need

Regarding need for services, the CHSC subgroup reports a lesser need than the SSI subgroup for 13 of the 14 listed services, all at a statistically significant level ($p \leq .05$). The range of reported need for the CHSC subgroup was 3-23% (mean=12%, median=9%) and for the SSI subgroup was 9-55% (mean=27%, median=26%). The least needed service for both subgroups is a personal attendant, while the most needed service for the CHSC subgroup is day care and for the SSI subgroup is cash assistance.

The Urban subgroup reports a greater need than the Rural subgroup for 8 of 14 listed services, none at a statistically significant level. The range of reported need for the Urban subgroup was 6-28% (mean=16%, median=15%) and for the Rural subgroup was 5-32% (mean=16%, median=14%). The least needed service for both subgroups is a personal attendant, while the most needed service for the Urban subgroup is cash assistance and for the Rural subgroup is parent networking.

Service Availability

Of those responding "yes" to a service need, corresponding service availability was reported as greater by the CHSC subgroup for 10 of the 14 services. The only statistically significant difference was more availability of day care reported by the CHSC subgroup. The range of reported availability for the CHSC subgroup was 48-89% (mean=78%, median=83%) and for the SSI subgroup was 44-94% (mean=70%, median=75%). The least available service for both subgroups is a social support group, while the most available service for both subgroups is home care (tied with respite care in the CHSC subgroup).

Of those responding "yes" to a service need, corresponding service availability was reported as greater by the Urban subgroup for 7of the 14 services. No differences were statistically significant, although greater availability of respite care for the Urban subgroup approached significance ($p < .07$). The range of reported availability for the Urban subgroup was 47-92% (mean=75%, median=79%) and for the Rural subgroup was 50-92% (mean 75%, median 79%). The least available service for the Urban subgroup is social support groups for teens and for the Rural subgroup is parent networking, while the most available service for the Urban subgroup is mental health counseling and for the Rural subgroup is home care.

Service Usage

Of those responding "yes" to both service need and service availability, corresponding service usage was reported greater by the CHSC subgroup for 9 of the 14 services. Statistically significant

differences were more usage of day care and financial counseling by the CHSC subgroup. The range of reported usage for the CHSC subgroup was 50-93% (mean=76%, median=76%) and for the SSI subgroup was 20-97% (mean=67%, median=76%). The least used service for the CHSC subgroup is social support groups and for the SSI subgroup is financial counseling, while the most used service for both subgroups is transportation.

Of those responding "yes" to both service need and service availability, corresponding service usage was reported greater by the Urban subgroup for 7 of the 14 services. No differences were statistically significant, however, suggestive differences were greater use by the Rural subgroup of trade and technical training ($p<.06$), home care ($p<.09$), and recreational services ($p<.08$). The range of reported usage for the Urban subgroup was 42-94% (mean=71%, median=73%) and for the Rural subgroup was 43-100% (mean=75%, median=82%). The least used service for the Urban subgroup is trade and technical training and for the Rural subgroup is financial counseling, while the most used service for the Urban subgroup is cash assistance and for the Rural subgroup is transportation (tied with home care).

Service Satisfaction

Of those responding "yes" to service need, service availability, and service use, corresponding satisfaction was reported greater by the CHSC subgroup for 8 of 13 services (satisfaction rate was tied for one service). There were no statistically significant differences between the CHSC and SSI subgroups in satisfaction with any of the 14 services. The range of reported satisfaction for the CHSC subgroup was 75-100% (mean=90%, median=91%) and for the SSI subgroup was 71-100% (mean=89%, median=91%). Given relatively high satisfaction for all the support services, the least satisfactory service for the CHSC subgroup is trade and technical training and for the SSI subgroup is personal attendant. The most satisfactory service for the CHSC subgroup is vocational counseling (tied with personal attendant and home care) and for the SSI subgroup is financial counseling (tied with trade and technical training, social support group, and recreational services).

Table 18 presents a summary of open-ended responses given by the CHSC and SSI subgroups for dissatisfaction with any of the 14 community services. Allowing that any one respondent could give more than one reason for dissatisfaction, there were 29 reasons from 22 respondents in the CHSC subgroup and 44 reasons from 36 respondents in the SSI subgroup.

TABLE 18

Reason for Dissatisfaction with Other Community Services	*# of Reasons (CHSC Subgroup)*	*# of Reasons (SSI Subgroup)*	*Response Examples*
Service insufficiently available / service understaffed	7	10	"so far we've only found two people willing to do respite; I can't always get them when I would like to do something" "not available when needed" "I feel the community needs more activities and/or support groups for the young teens" "need more help groups; have none (to our knowledge) at the moment""
Service difficult to find / no help provided to find service	2	3	"we have had to do a lot of searching for service ourselves and that is hard and very stressful" "wish it were easier to locate needed services; we feel we've had to discover anything out on our own and may miss an opportunity that would be beneficial to our child"
Provider performance or attitude below expectation	3	10	"the daycare lost my son" "treated like a baby" "poor performance of duties" "the transportation man was rude" "I was not satisfied with legal services for I felt not enough was done" "when you use them they think they own you and besides, I won't beg"
Service does not meet special needs of child	4	3	"most recreation does not seem to accommodate for people with mental disabilities" "we need more training for teens and when they get out of school" "trade and technical training at school is limited to those that have time in their schedules due to shortened school days; classes she's taken are very lacking in current technology"
Cash assistance insufficient / not always available	5	7	"dissatisfied with cash assistance – not getting enough because I was honest on the forms and it has hurt me" "cash: when it's really needed, it's not available" "human services through the State does not cover all our expenses by any means" "SSI that my son receives isn't always available to us due to the caseworker overestimates our wages" "financial aid is needed but SSI doesn't feel her need is great enough; we make just over the financial guidelines"
Cost of service too high	5	2	"YMCA is too costly" "in our income level it is necessary to get what we can whenever we can" "never enough money for necessities"
Information about services / coordination of services poor	3	5	"it was hurried and not explained thoroughly in writing" "my desire was for an organized approach with written communication – that doesn't happen in this county" "my part in cost of treatment not explained to me until child was admitted to treatment" "many services I'm not sure how they may help me and my child or their title doesn't explain enough"
Other	0	4	"personal reasons" "I think he has been pushed aside by the community as well as the school system"

Of those responding "yes to service need, service availability, and service use, corresponding satisfaction was reported greater by the Urban subgroup for 6 of 9 services (satisfaction rate was tied for 5 services). No differences were statistically significant, however, suggestive differences were greater satisfaction by the Urban subgroup with day care ($p<.10$) and home care ($p<.10$). The range of reported satisfaction for the Urban subgroup was 75-100% (mean=92%, median=92%) and for the Rural subgroup was 67-100% (mean=90%, median=91%). The least satisfactory service for both subgroups is trade and technical training, while the most satisfactory services for the Urban subgroup (100% satisfaction by responding users) are parent networking, vocational counseling, personal attendant, and home care; and for the Rural subgroup (also 100% satisfaction by responding users) are respite care, parent networking, transportation, vocational counseling, social support groups for teens, and personal attendant.

SUMMARY OF RESULTS

Overall, results were notable for both the presence and absence of significant differences between subgroups on selected variables. Perhaps the most pertinent needs assessment question addressed satisfaction with the child's health care. The SSI group reported significantly less satisfaction than the CHSC group with the health care received by their children. Circumstances that may explain differing satisfaction levels include the greater severity of children's conditions in the SSI group, greater need for assistance organizing care in the SSI group, and lower average income in the SSI group. Nevertheless, a large majority of all responding families are moderately to very satisfied with health care services for their children with special health care needs. While pleased with the overall expression of satisfaction with health services, the SSI subgroup results give reason for concern. Providers of services to children with special health care needs should give some extra consideration to the quality of services to families of children on the SSI program. This recommendation probably can be extended to any family of children with special health care needs where the child's condition is severe and the family's financial resources are limited.

Open-ended responses addressed a variety of reasons for dissatisfaction, but the two most frequent reason categories were complaints of physician incompetence or lack of thoroughness, and complaints related to treatment approaches. When considering the full array of reasons for dissatisfaction, it appears that for both subgroups (CHSC and SSI), reasons are more often related to perceived provider performance and procedures than to the specific logistics of accessing care. This finding can be interpreted as a passing grade for the structural components of the health care system for children with special health care needs, but the quality of care processes could use improvement.

While noting the greater dissatisfaction with health care in the SSI sample versus the CHSC sample, there is not a standard acceptable level of dissatisfaction commonly used to judge quality of care to children with special health care needs. Comparison of needs assessment findings to some standard would be useful to the determination of need and subsequent program priorities and modifications. Regardless of the presence of a standard, this study suggests that the population of children with special health care needs is not homogenous regarding its need for and satisfaction with health care services. This study does well to dispel any misconception that children with special health care needs are all somehow similar. The study also affirms that Iowa's service system is not yet providing a comparable health care experience for all children with special health care needs and their families.

These assessment study findings provide needs-based evidence supporting several of the next five-year program cycle performance measures and CHSC priority program areas. Especially relevant are the state-negotiated performance measures addressing quality of care for CSHCN in managed care programs generally and as delivered to CSHCN by primary care practitioners specifically. The assessment suggests that quality of care may be of greatest benefit to families with more severely affected children. Given the higher reported need for an array of support services among families with more severely affected children, the care coordination priority program area should prove a valuable asset to families who need to access and organize many community resources. Assessment findings also support the worthiness of pursuing the medical/health home national performance measure as it promotes service system characteristics that will enhance quality, service coordination, and family-centered practices.

3.1.2 Needs Assessment Content

3..1.2.1 Overview of the Maternal and Child Health Population Health Status

The following section describes the health status of Iowa's MCH population, including priority health problems, health service gaps, system constraints, and strengths/weaknesses of the service system.

Iowa's rural counties are losing population while the cities, specifically Des Moines and the Cedar Rapids-to-Iowa City corridor are growing. While growing families are moving into the urban areas in search of employment, the rate of unemployment in Iowa has dropped to the lowest rate in years at 2.5%.

The percent of Iowa families living at or below the federal poverty level has been steadily declining since 1990. Current data (1996-98 average) reports an overall poverty rate in Iowa of 9.4%. The ratio of women to men in poverty follows the national trend, at a ratio of 1.4 to 1.

In 1996, 23% of Iowa's children under age 18 lived in single-parent households: an increase from 19% in 1985. The National Centers for Disease Control estimates that 80% of single family households are headed by females, and 20% of single family households are headed by males.

As discussed previously in section 1.4, Iowa's minority populations are growing in both absolute numbers and percentage of total population, with non-white births increasing from 4.3% of total live births in 1990 to 6.0% in 1998.

Health Status of Women and Infants

In Iowa, live births to women 20 years old and under have been stable at 10% of total births for the last decade. The birth rate to women 15 to 19 years old has gradually decreased from 4.2% in 1991, to 3.5% in 1998. The low birth weight (LBW) and very low birth weight (VLBW) rates in Iowa in 1998, were 6.4% and 1.3% respectively. During the same time period, these rates have been two or more times higher in black women than the rates in white women, at 10.5% to 14.7% for LBW births and 2.4% to 3.8% for VLBW births.

The most recent report based on 1997 Medicaid data indicates that:

- Newborns received Medicaid coverage was 30.6%.
- approximately 66% of pregnant women covered by Medicaid are 24 years of age or younger, higher than the percentage in the non-Medicaid population (22%),
- Medicaid paid for 59% of all births that occurred out of wedlock,
- pregnant women on Medicaid tend to demonstrate more medical risk factors than non-Medicaid mothers, (18.8% vs. 17.6%)
- the rates of LBW and VLBW per 1,000 births for those newborns covered by Medicaid were higher (1.4 and 6.3) than the rates for non-Medicaid population (1.2 and 4.6)
- the mean birth weight of Medicaid covered babies was about 100 grams lighter than that of non-Medicaid born babies.

The 1999, Iowa Behavioral Risk Factor Surveillance System (described in Section 3.1.2.4 Population Based Services) indicates that among 25-34 year old females, 31.7% are current smokers. Smoking among females age 18-24 showed an increase from 30.1% in 1998, to 41.5% in 1999, while binge drinking among this group decreased from 31.3% in 1998, to 24.4% in 1999. In 1999, Behavior Risk

Factor Surveillance System (BRFSS) data indicated that approximately 41,200 Iowa women (ages 18-44) had a financial barrier in attempting to access care as evidenced by the following:

- 12.3% of 18-24 year old females, 10.5% of 25-34 year old females, and 9.2% of 35-44 year old females had no health coverage.
- 8.5% (18-24 year old females), 8.9% (25-34 year old females), and 6.1% (35-44 year old females) reported that cost was a barrier to accessing medical care in the previous year.

BRFSS study results and birth certificate records from the past five years indicate that more than 85% of pregnant women in Iowa start prenatal care in the first trimester. However, by the Kotelchuk Index, newly released from the federal MCH Bureau, only 70% of Iowa women received adequate prenatal care during pregnancy for the most recent five-year period. This is lower than the Federal Title V expected percentage (80%). The adequate prenatal care rate for black women has been around 55% from 1995 to 1998. Unintended pregnancy in Iowa has been stable at 35% for this decade.

Reported increases in chlamydia and gonorrhea cases in the last two years have resulted from two recent screening changes in Iowa. First, in late 1997, the STD/HIV prevention program began working with the Iowa Department of Human Services to bill Medicaid for STD/HIV services provided to Medicaid-eligible clients. This change resulted in expansion of the screening program. Second, in 1998, the state chlamydia and gonorrhea testing program, in conjunction with the University of Iowa Hygienic Laboratory, began testing with an amplified DNA probe, resulting in an increase in the sensitivity and specificity of the test. Since syphilis morbidity in Iowa peaked in 1995 at over 100 cases per year, the incidence has continued to drop (64 cases in 1996, 32 cases in 1997, 25 cases in 1998), indicating that the state of Iowa may have a real chance for the total elimination of endemic syphilis.

Health Status of Children

The rate of children under 19 without health insurance (at or below 200% of the federal poverty level) is decreasing in Iowa, reaching 6.3% in the1996-98 average. This is partially the result of HAWK-I, Iowa's state child health insurance program. A baseline survey was conducted with parents of children enrolled in HAWK-I. The purpose of the survey was to collect information about the children's access to health care services, health status, and insurance coverage prior to joining the HAWK-I program. The survey took place from March 1999 to July 1999. The results of the survey clearly showed uninsured children needed access to mental health and dental health services prior to entering the HAWK-I program.

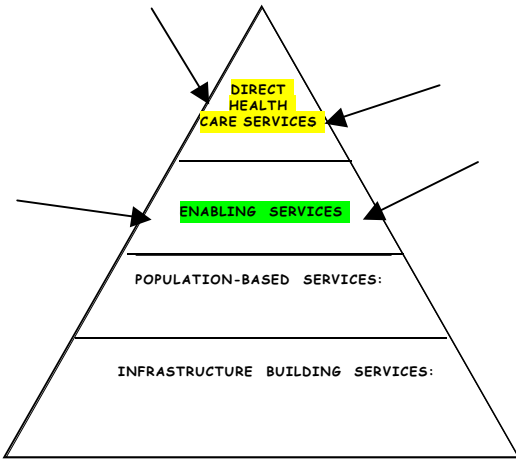
Ninety-two percent of youth have received educational information about HIV/AIDS. About 13% of sexually active youth report that they don't use any kind of birth control.

The YRBS data indicates obesity is also becoming a huge problem for children and adolescents in Iowa. The self estimated obesity rate is 39.2% for females and 23.7% for males.

In 1998, 12.4% of children 6 years or younger had blood lead levels greater than 10ug/DL, which is three times higher than the national level. Of these same children, 5% had blood lead levels greater than 15ug/DL, also three times higher than the national level. There has been no significant change in high blood lead levels in children since 1992 in Iowa. Lead poisoning continues to be of concern as 42.9% of the houses in Iowa were built before 1950.

A statewide dental survey in 1999 indicated that 30% of second to fourth graders in Iowa public school districts did not have dental insurance. In the same age group, 15% of the children had not seen a dentist in more than one year or had never seen a dentist. About 14% of the children had untreated dental caries. Children eligible for the free or discounted school lunch program seemed to visit the dentist less often than those who were not eligible for the program. These children also had significantly more decay and untreated cavities.

3.1.2.2 Direct Services
3.1.2.3 Enabling Services



In the following section the priority state concerns for the Title V population groups are addressed as they relate to the two upper levels of the MCH pyramid, encompassing both direct and enabling services. For each of the three Title V population groups, subsections address concerns related to:

- access to health care,
- health-related services from the perspective of financial access,
- cultural acceptability,
- availability of prevention and primary care services, and availability of specialty care services.

PREVENTIVE AND PRIMARY CARE SERVICES FOR PREGNANT WOMEN, MOTHERS, AND INFANTS

Summary of Family Planning Needs. IDPH is one of two grantees in Iowa providing Title X services and has responsibility for 45 of the 99 counties. Six of those 45 counties do not have family planning services available, and ten counties have services available on a very limited basis -- less than once per week. Twenty-one counties have mini-clinics for education and counseling where clients must either travel outside the county to a full service family planning clinic or access medical services from a private provider. Of the counties with limited family planning services, 12 are designated federal Health Professional Shortage Areas (HPSA). Most health professionals in shortage areas must focus on serving the predominantly elderly population, not women of reproductive age.

It is projected that increasing numbers of Hispanic women of reproductive age will need subsidized family planning services within the IDPH service area. The Hispanic population is projected to increase in all Iowa counties. The greatest increase within the IDPH service area is anticipated in Crawford, Dallas, Polk, Franklin, and Black Hawk counties.

Increasing Cultural Diversity. In Iowa, cultural acceptability of services takes on new meaning each year as the cultural diversity of the state's population increases. Language and cultural barriers create increasing need for creativity and sensitivity in the delivery of services to such diverse Iowa populations as Sudanese and Bosnian immigrants. As these newly-arrived populations join Iowa's cultural mix of African American, Native American, and Hispanic families, the determination of cultural competence and cultural acceptability becomes more difficult.

According to the Iowa Bureau of Refugee Services, there were an estimated 20,202 refugees resettled in Iowa in FFY98, 633 more than reported in FFY97. Refugees from Southeast Asia and Eastern Europe arrive in Iowa speaking a variety of languages and dialects. The availability of interpreters and provision of services to these immigrants present significant challenges.

In addition to the legal immigrants, including the resettled refugees, an increased number of local MCH agencies report the need to serve a growing number of undocumented families, with many from Mexico, Central America, and the Latin American/Caribbean areas. However, attempts to verify estimated numbers highlight the lack of data bases that accurately enumerate the immigrant population. The Immigration and Naturalization Service has opened two offices in Iowa, one in Cedar Rapids and one in Des Moines.

The ethnic composition of Title V maternal health clients has changed significantly since the beginning of the decade. From 1990 to 1995 the number of Hispanic women seen at Iowa's Title V maternal health clinics increased 219%. From 1995 to 1998 the increase was 140%. While there has been a general increase in the utilization of maternal health clinics, much of this increase was due to the previously mentioned influx of Hispanic women.

Maternal Mortality Review. Maternal deaths are identified by the IDPH Bureau of Vital Records. The Iowa Medical Society presently reviews these maternal deaths. The review committee meets on an "as needed" basis as maternal deaths are reported. The Iowa Department of Public Health presently has no statutory authority for the maternal mortality review process, but has met with the Medical Society with whom they are planning a more predictable process.

Black/White Disparities in Infant Mortality in Iowa Consistently higher black infant mortality rates contrasted with low and declining white infant mortality rates signal a public health problem in Iowa. Black infants account for only 3% of total annual births but comprised about 7% of state total infant deaths for the past decade. By 1998, the death rate for black infants was 18.5 deaths per 1,000 live births, while the rate for all other infants was 6.1 deaths per 1,000 live birth.

In a 1999 IDPH study, birth and death certificates for 1995-1998 were matched; these included 145,428 white births and 4,328 black births, and 917 white infant deaths and 85 black infant deaths. Overall, black infants were slightly more premature than white infants (gestational age 38.4 *vs*. 39 weeks) and of lower birth weight (3098g vs. 3405g). Blacks were twice as likely to be of LBW, and three times as likely to be of VLBW. Black mothers were more likely to be younger (23.6 yr. vs. 27 yr.); to be unmarried at birth (73.9% vs. 24.7%), to have more medical problems during pregnancy (33.1% vs. 23.7%) and to have less adequate prenatal care based on the Kotelchuk index (55.7% vs. 71.1%).

Differences in rates of low birth weight account for the majority of black/white disparities in infant mortality in Iowa. Less adequate use of prenatal care, unaddressed maternal health problems, and lower levels of social support may be contributing factors. Since many of the determinants of infant mortality are amenable to change by existing public health programs, and since there are only about 20 black infant deaths annually, the scale of the problem is manageable if intervention strategies can be targeted to serve black communities in the state.

Access to Prenatal Care. The ongoing Access to Prenatal Care Project indicates that identified patterns are continuing. The increased need for services to minority women will likely increase the reports of barriers to care.

Care coordination services are available to all pregnant women served by maternal health centers. Community based centers provide a package of support services known as enhanced services. Enhanced services include: prenatal and postpartum medical care, health education, and care coordination. Additionally, for women determined to be at high-risk based on a specified health assessment, the following services are provided: development of an individualized plan of care based on the client's needs and provision of all appropriate components of care (medical, education, nutrition, psychosocial, and postpartum home visit).

Unintended Pregnancy. The Iowa Barriers to Prenatal Care Project purpose was to obtain accurate information about women and their pregnancies. This project is a cooperative venture of all Iowa's maternity hospitals, the Statewide Perinatal Program, the University of Northern Iowa Center for Social and Behavioral Research, and IDPH. The Robert Wood Johnson Foundation funded the first three years of the project. The current funding is provided by the IDPH.

A comparative analysis of variables based on the mother's desirability of pregnancy showed an increased use of cigarettes during pregnancies among mothers who did not desire pregnancy. Twenty-one percent of mothers smoked one to ten cigarettes and 18% smoked 11 to 20 cigarettes during the unintended pregnancy. Desirability of pregnancy varied as a function of race/ethnicity. One-third of whites (34%) and one-third Asians (39%) were likely to desire pregnancy compared to 14% of African Americans, 17% of Native American and 27% of Hispanics. Mothers not desiring pregnancy were the least likely to seek prenatal care. They also reported the least number of prenatal visits.

Termination of Pregnancy Report. Preliminary baseline data on spontaneous abortions and terminations of pregnancy were collected for the first time in Iowa beginning July 1, 1997. A report presenting this data was published in March 2000 and covers the data from January 1999 through December 1999. The Iowa reporting system uses reporting formats developed by the National Center for Health Statistics in 1987.

The purpose of the termination of pregnancy surveillance is to determine if there are areas of the state with higher than expected rates of spontaneous pregnancy loss. The surveillance gives state

health planners the information needed to address related issues regarding pregnancy loss if specific patterns are identified. The data can also be used to address issues related to family planning, maternal and child health, access to health care, quality of care, and sexuality education.

A total number of 7,325 terminations were reported during the time period (January 1999 – December 1999). Of these, 5,732 were reported as induced 1,587 were reported as spontaneous, six were not identified as to type.

The rate of induced pregnancy was the highest at ages 21 and the spontaneous terminations were most frequent around age 26.

The complete report can be found in the Iowa Termination of Pregnancy Report, March 2000 from the IDPH Center for Health Statistics.

Medicaid/Birth Certificate Matching Files Analysis of 1997. Since 1988, the Iowa Department of Public Health has been linking Medicaid pregnancy and birth claims data to birth certificates. Changes in the Medicaid program have altered eligibility and service benefits. These changes include:

- increased eligibility to 185% of poverty for pregnant women and infants,
- presumptive eligibility determinations for pregnant women,
- enhanced services and case management for pregnant women,
- risk assessments for pregnant women, with increased payments for high risk, and
- MediPass and Health Maintenance Organization (HMO) contracts for Medicaid clients.

Linking the two data sets has allowed evaluation of the impact of these changes on birth outcomes in the Medicaid population. Initial analyses using the 1988 through 1992 data demonstrated the positive impact that enhanced services/case management had on birth outcomes.
The current (1997) analysis focused on differences among enrollment option, the utilization of services, and outcomes.

Observation from the 1997 analysis concluded that Medicaid continued to be the primary source of payment for obstetric services for younger women and women who are unmarried. Enhanced services continued to yield an increase of birth weights and adequacy of prenatal care. Women who received these services were more likely to receive adequate prenatal care.

Based on the outcomes observed, the following recommendations were made.

- The risk screening and enhanced services programs should be continued.

- Efforts should be made by DHS and DPH to strengthen the relationship between managed care providers and designated maternal health centers.
- Educational efforts should include the importance and benefit of these services.
- The expectations of the Medicaid program with regard to prenatal services should be clarified for providers.

Iowa Pregnancy Nutrition Surveillance System. The CDC Pregnancy Nutrition Surveillance System (PNSS) monitors behavioral and nutritional risk factors among low-income pregnant women participating in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) in Iowa. Low-income women enrolled in the WIC program experience improved dietary intake, appropriate prenatal weight gain, and earlier prenatal care than women who have not enrolled. Benefits are most apparent for women who enroll early in pregnancy; their infants are less likely to be premature and have a low birth weight. Almost 61% of pregnant women in Iowa were enrolled in WIC before the end of their second trimester (1998 data). The following table shows when pregnant women, enrolled in the Iowa WIC program, sought medical care.

Trimester of Entry Into Prenatal Care For WIC Participants (1998)

Trimester in which Medical Care Began	Percent of pregnant Women enrolled in Iowa WIC
First trimester	77.6 percent
Second trimester	7.6 percent
Third trimester	1.1 percent
No medical care	13.7 percent

Source: Iowa Pregnancy Nutrition Surveillance System

PREVENTIVE AND PRIMARY CARE SERVICES FOR CHILDREN

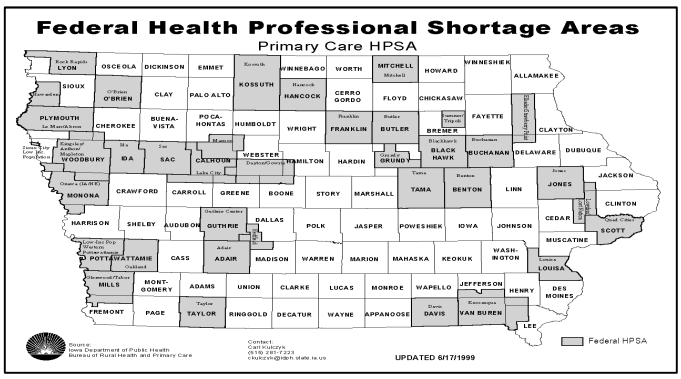
Uninsured Children. Legislation was enacted by the 1998 General Assembly to approve state funds to be used as the match for the federal initiative, "State Child Health Insurance Program" (SCHIP). SCHIP legislation estimated that there are 67,000 children (under the age of 18 and below 185% of federal poverty guidelines) in Iowa who may benefit from health insurance coverage. Iowa chose both to expand Medicaid to 133% of the federal poverty level, and to begin a private subsidized health insurance program. HAWK-I (Healthy And Well Kids in Iowa), was designated to help cover children with family incomes from 133% to 185% of the poverty level. Data through March 2000 show enrollment of 6,071 children in HAWK-I and 7,895 children in Medicaid expansion.

Changes in HAWK-I and Medicaid legislation in 1999 facilitated outreach activities. A requirement that the third party administrator of HAWK-I provide outreach services was removed. Additionally, rules were adopted by the HAWK-I Board to apply "economic hardship rules," and increase premiums for managed care organizations. Changes in state Medicaid legislation removed the requirement of a face-to-face interview for enrollment and also eliminated the financial assets test, which began July 1, 1999.

Following the enactment of HAWK-I and the Medicaid expansion, Iowa began Phase I of outreach. A media campaign initiated through a contract with a local advertising agency fell short of the hoped for response. Phase II of outreach began in FFY00 and worked through local community-based agencies organized by DHS regions. The Iowa Covering Kids grant assists in developing an outreach system. Collaborative activities among private and public agencies have been instrumental in addressing barriers to enrollment. Progress in reducing the percent of uninsured children is addressed in 1.4 Overview of the State (pages 7-8).

Primary Care Access In November 1999 the Primary Care Office of the Iowa Department of Public Health reported that the following primary care shortage area designations existed in Iowa:

- Primary Care HPSAs: There were 37 primary care Health Professional Shortage Areas (HPSA) in 49 of the 99 counties of Iowa. There were 32 geographic designations, 5 population group designations, and 1 facility designation (an increase of 3 geographic, 1 population group, and 1 facility designation since 1998).



- Medically Underserved Areas (MUA): Medically Underserved Area designations existed in 62 counties, with 52 counties receiving partial designations while 10 counties had full county designations.
- Mental Health HPSAs: There were seven of sixteen Mental Health Catchment Areas

designated as Mental Health HPSAs, encompassing 57 counties in Iowa. An additional four catchment areas, comprised of 24 counties, will be submitted for designation by February, 2000.

- Dental HPSAs: There were three Dental HPSAs in the State of Iowa, consisting of one geographic designation and two low income population designations.
- Governor's Designated Shortage Area: Of Iowa's 99 total counties, 59 rural counties were designated as Governor's Designated Shortage Areas. This state designation is for rural health clinic certification status.

Children's Mental Health Services. In December of 1997, the Iowa State Mental Health Advisory Planning Council, through the Department of Human Services, engaged the Technical Assistance Collaborative, Inc. to undertake an evaluation of Iowa's public mental health service system. The scope of the project included evaluating Iowa's Medicaid behavioral health managed care program; portions of the Medicaid mental health system that operated outside the managed care program; community and institutional mental health services managed by Iowa's counties; children's mental health services managed by DHS and Area Education Agencies that play a role in children's mental health. Evaluators conducted key informant interviews and focus groups with stakeholders; documents and available data bases were reviewed. The evaluation found that barriers to care in Iowa's public mental health services included:

- legal barriers related to limited statutory requirements for the provision of care,
- political barriers related to a lack of understanding about mental illness, lack of shared vision coupled with a spirit of animosity among the constituencies responsible for problem solving, heavy reliance on property tax and a long history of trying to find quick fixes rather than fundamental structural reforms,
- organizational barriers arising from multiple systems of care that contribute to a fragmented system of services, and
- financial barriers related to complicated funding streams and the limited nature of Iowa's Medicaid system.

The evaluation found that Medicaid is primarily used to fund traditional inpatient and outpatient services while the field has moved beyond the traditional services to a broader array of psychosocial and community support services.

Both providers and consumers pointed to the scarcity of children's services and the difficulty in accessing services that are available. Additionally, the transition of adolescents into the adult mental health system was identified as a significant gap in the system.

The majority of publicly funded children's mental health services are provided by DHS as part of

the overall child welfare system. While expansive, the system is directed more toward institutional and residential care rather than outpatient and community support services. Specifically, the report notes, "there appears to be no defined set of child mental health services as found in other states under the federal Child and Adolescent Service System Program (CASSP)" (*Quick Fixes or Structural Reform: An Evaluation of Iowa's Public Mental Health System*, Technical Assistance Collaborative, Inc, December 1998). The lack of a discrete appropriation dedicated to funding a defined set of children's mental health services is a major impediment to the development of a children's mental health system in Iowa. The Iowa Maternal and Child Health Advisory Council is engaged in reviewing the report and developing recommendations.

Child Care In 1999, the Iowa families included 499,020 children from birth to 12 years old. Many of these families are faced with the challenge of finding appropriate child care during times of work, education, and recreation. At the beginning of 2000, Iowa had 1,538 licensed child care centers and 5,280 registered child care homes. The number of children receiving child care in unregistered accommodations is not known. Eighty-three percent of Iowa families with children age 6 to 17 have both parents, or the only parent in the home, employed. Each day, 180,000 children in Iowa receive care outside the home.

The MAP to Inclusion Child Care Committee is a statewide initiative charged with examining the integration and accessibility of child care to disabled children and children with special health or developmental needs. The purpose was to explore the experiences of families and child care providers with regards to child care for special needs children. The following is the executive summary from the data of the study. Iowa families that have children with special developmental or health needs experience multiple barriers to quality child care.

- Iowa child care providers desire on-site support and training in order to provide quality child care to children with special developmental or health needs.
- Financial barriers: Cost was the number one barrier to quality child care cited by families. Many families are deeply in debt as a result of mounting medical expenses incurred by their child with special needs, yet many Iowa families have incomes "too high" to qualify for assistance.
- Policy barriers: Families struggle to understand the various programs, policies, and program eligibility tied to each program. The paperwork required to apply for services is overwhelming and often redundant.
- Availability & accessibility barriers: There is a scarcity of child care options in many Iowa communities. Some Iowa communities lack even a single child care center and have few, if any, in-home providers. Only a fraction of child care providers accommodate or accept children with

special needs.

- Public agency communication barriers: Families that have children with special needs must work with multiple agencies and case managers, many of whom are not fully informed about their own and each other's programs and give conflicting information which leads to inconsistent and fragmented services.

- Child care provider barriers: High personnel turnover among child care providers leads to unmet needs and inconsistency in service quality and continuity. Many child care providers are ill prepared and do not have the support needed to care for children with special needs.
- Logistical barriers: Families that have children with special needs have multiple specialty service providers that provide intervention services for the child. Scheduling treatments, interventions, and services creates problems for families and child care providers.

The conclusions of the MAP to Inclusion study are:

- Child care is as much of a need (possibly even a greater need) for families with special needs children than for families without special needs children.
- The fact that the demand for special needs child care is undocumented does not mean the need does not exist.
- Human service agencies and organizations focused on the issue of child care need to be more visible, accessible, and user-friendly to both families and child care providers.
- Child care providers lack the necessary training to care for children with special needs.

The following are recommendations the group has made.

- State System: Government agencies should collaborate to restructure public program eligibility guidelines and application procedures. State regulations should be reviewed and revised to accomplish this recommendation. The State should apply for federal waivers to make federal programs for children with special needs more accessible to Iowans. Iowa should explore the possibility for a "passkey" approach for children and families to access services and funding resources. Government should collaborate with private business and industry to build a system of tax incentives or like incentives for business and industry involvement in child care initiatives.
- Community: Public funds should be made available to communities to build capacity at the community level to serve families that have children with special needs. Public funds should be made available for incentive grants to child care providers and related service providers to serve children with special needs.

- Child Care Provider: Training should be available to providers regarding care for children with special needs. Increases in child care subsidy rates for children with special needs should be secured. Public and private funds for provider support initiatives should be made available.
- Family: Families should have ready access to information regarding the community-based and state public programs available to support the family. Families should have simplified application procedures to use when applying for services or assistance.

SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The needs assessment process (described previously) emphasized two emerging priority needs, which continue to persist. First, there is an identified need for mental health/behavioral services to be delivered by providers trained in child and adolescent mental/behavioral health. In FFY98, approximately 25% of children (over 1,300) receiving CHSC services have a diagnosis that can generally be classified as a mental health or behavioral problem. It has been a long-standing experience of CHSC regional health service coordinators that there is limited availability of community-based providers trained in the care of pediatric patients with mental health or behavioral problems. This results in lack of treatment or, occasionally, treatment by a provider specializing in adult care. Although mental health services remains a priority, the needs prioritization process ranked this as a second level priority issues. This means that, at least for this first year or two of the upcoming 5-year planning cycle, CHSC will be dedicating a greater share of program resources to other priorities. It must be noted, however, that mental health services continue as one of the state-identified priority needs, but the MCH program will assume responsibility for promoting system improvements and monitoring the associated performance measure. CHSC expects to closely collaborate with MCH in this endeavor.

Second, there is an identified need for improving the approach to caring for CSHCN enrolled in managed care plans. This is because the care provision structures of managed care organizations are, to some degree, inadequate to address the wider array of health and health-related needs of CSHCN. These needs may be for highly specialized clinical or support services, which because of generally low demand, are often not available within the physical or benefit structures of managed care organizations. Therefore, families may have to seek needed specialty services elsewhere or perhaps accept services and providers not best matched to the child's special circumstances. For example, CHSC regional health service coordinators have frequently been denied as specialty providers for managed care plan enrollees in favor of less qualified within-plan providers. In late

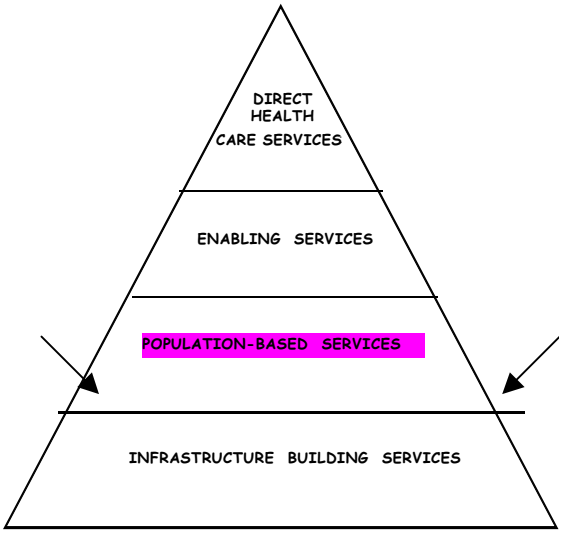
1998, a special legislatively mandated subcommittee was charged with assessing the needs of CSHCN who would be enrolled in the HAWK-I Children's Health Insurance Program. In early 1999, the subcommittee submitted CSHCN-related recommendations to the Board in charge of implementing HAWK-I. The recommendations are currently in the process of being considered.

There are several newly identified needs related to CSHCN that locate in the pyramid levels. First, is the need to systematically and comprehensively review both the mobile and regional direct clinic service offerings. The mobile clinic system receives the higher priority, primarily because of its sometimes unclear relationship to outreach clinics offered by other provider entities. Tied closely to this review will be an awareness of possibilities for telehealth technologies to deliver certain services more inexpensively or where services were previously undeliverable. As CHSC strives to be more competent and contributory regarding core public health functions, direct service offerings must be assessed for their necessity in an environment of market expansion by direct service providers. Increasing enrollment by families in the Iowa SCHIP also motivates CHSC to review and revise direct care services. This review should ultimately result in improved joint planning and coordination by provider entities that have formerly been more isolated in exercising programmatic changes.

The broad area of care coordination services received a top priority rating for this next five-year cycle. In large part, this is due to the rapidly expanding recognition of CHSC as the state's expert in coordinating community-based services for severely involved CSHCN. The regular and continuing expansion of the Ill and Handicapped Waiver Program has resulted in major staff and budget increases within CHSC to maintain care coordination responsibilities formalized in an interagency agreement with the Iowa Department of Human Services. Beyond the IH Waiver Program, there are increasing opportunities for CHSC to be the community-based care coordinator for CSHCN returning home after discharge from major medical centers. Arrangements for systematic hospital-to-community continuity of care procedures needs to be investigated.

A second level priority enabling service involves a role in the child care system as consultants for issues related to CSHCN in the child care environment. Most frequently, this role will be as short-term trainers or technical consultants, but may also be as infrastructure builders when serving on state committees and task forces charged with planning policy, data, assurance, and other system development activities.

3.1.2.4 Population Based Services



This section addresses the priority state concerns for the Title V population groups as they relate to the population based services level of the MCH pyramid. For each of the three Title V population groups, subsections address concerns related to:

- state coordination among agencies and organizations,
- geographic availability, and
- funding mechanisms.

PREVENTIVE AND PRIMARY CARE SERVICES FOR PREGNANT WOMEN, MOTHERS, AND INFANTS

Iowa Behavioral Risk Factor Surveillance System Survey. The Iowa Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing monthly telephone survey of adults in the state. The risk behaviors surveyed are major contributors to illness, disability, and premature death. The following information is based on data collected during 1999. A total of 3,618 individuals were surveyed during this summary period.

- Health Care Coverage: Of those surveyed, 8.8% reported having no health care coverage. Highest levels of non-coverage were in the 18-24 year age group at 14.1%. Of those in the under $15,000 income range, 18.1% reported no health care coverage.
- Cigarette smoking: In Iowa, the percent of adult smokers steadily increased from 1989 to 1992, then declined to 23.4% in 1999. However, young female smokers (18-24 years old) have shown a marked increase, at 41.5% in 1999, up from 30.1% in 1998. The group with annual incomes of $15,000 or less has a higher percentage of current smokers than any other income group.
- Alcohol consumption: There were 18.2% of Iowa adults reported as binge drinkers in 1999. Another 4.4% were chronic drinkers.
- Body weight: In 1990, the rate of obesity among adult Iowans based on the Body Mass Index (determined by taking body weight in kilograms and dividing by height in meters squared) was one in four (25%), and in 1999 the rate was more than one in three (35.8%). The population group with the highest percentage of obesity in 1999, at 42.5%, included those adults without a high school education.
- Safety belt usage: In 1997, 32.7% of respondents reported not using their seat belt. When Iowans who had a child five through fifteen years of age were asked how often the oldest child wore a seat belt, 71.3% reported "always"; 17.3% reported "nearly always". Children ages four and under were reported by 919.9% parents to be in a car safety seat at all times when traveling in a car. No new data was collected in 1999.
- Bike helmet usage: Parents reporting that their children age five through fifteen wore a bike helmet at all times stood at 17% in 1997, while 48.9% reported that their children seldom or never using a helmet. No new data was collected in 1999.

Regional Genetic Needs Assessment

A comprehensive needs assessment was conducted by the Regional Genetic Consultant Services. The Regional Genetic Needs Assessment primary purpose was to provide genetic health care services and education for individuals and families within the State of Iowa through statewide outreach services. The aim is to reduce the incidence of birth defects and improving outcomes, and promoting health and prevention of disease for children and families with diagnosed or undiagnosed genetic conditions.

One recommendation for utilization and need for underserved and at risk populations was to increase promotion of and education about available Regional Genetic Consultation Services (RGCS). A few strategies are:

- Open dialogues with local prominent health care providers and educators in order to increase awareness of the RGCS program and the need for genetic services.

- Distribute promotional material to local physicians, nurses, and clinic staff informing them of RGCS services, clinic sites, contact information, and appropriate conditions of referrals.

The second recommendation is the expansion of RGCS services. Some of the strategies are:

- Increase identification and provision of services to patients/families with common Mendelian disorders for which new diagnostic tests and treatments modalities are available;
- Increase services to patients/families with disorders for which research is providing new information regarding genetic inheritability.

The third recommendation is to expand educational activities. Some ways RGCS are going to accomplish this are:

- Target educational efforts towards sub-specialty health care providers who currently under-refer patients with need for genetic services as determined by survey or referral;
- Continue involvement in medical Genetics course for UIHC medical students.

The final goal is to assure high quality medical genetic and educational services. A few ways of completing this are:

- Update data collection protocol;
- Review and adopt standards of care protocols for common genetic conditions as well as comprehensive patient history and assessment tools for use with the RGCS.

Neuromuscular Program Needs Assessment

The purposes of the Neuromuscular (NM) Program are to provide neuromuscular healthcare services and education for individuals and families with neuromuscular disease and to provide information about neuromuscular disorders to health care providers, educators, and others in the local communities. These services are often integrated with other programs servicing similar populations. Neuromuscular services are wide-ranging. Examples include, but are not limited to, diagnostic evaluation, case management of health care problems, patient education, and genetic counseling, physical therapy, psychosocial support, community education and connection to research opportunities. Through these services, patients gain access to specialized healthcare, efficient and accurate diagnosis, decreased morbidity, improved quality of life and knowledgeable communities.

The Neuromuscular and Related Genetic Disease Programs' contract with the Iowa Department of Public Health, Special Conditions, for Contracts has mandated a formal needs assessments for the state of Iowa. The following documentation reports in the needs assessment follow these focus areas:

- Utilization of neuromuscular services;
- Evaluation of existing services to assess quality, effectiveness and impart on the population served;

- Identification of under-served and at risk populations;
- Development of recommendations, priorities, and proposed strategies to address identified needs, unmet needs and gaps in services, and
- Assessment of educational services to the general public, healthcare providers and others as they pertain to neuromuscular and related disorders.

Each area of focus is stated as followed by a problem statement, questions to clarify the need for assessment activities followed by the assessment activities, and finally, the data gathered from the assessment activities. Conclusions are drawn from the needs assessment data to guide the NM Program in providing complete and excellent care to Iowans with neuromuscular disease.

Universal Newborn Hearing Screening Initiative For the past seven years the IDPH has taken the leadership role in establishing a universal newborn hearing screening program in Iowa. Through collaborative efforts with IDEA, Part C funds, a 28E Agreement exists between IDPH and University Hospital School in Iowa City for the implementation of the newborn hearing screening system. The associated data management and tracking system is located at University Hospital School and is accessible to IDPH at any time.

The IDPH encourages Iowa hospitals to provide hearing screening for all newborns as a standard of care. As of May 2000, 81 hospitals were screening newborns for hearing prior to discharge, which represents 97% of al births in the state. Of these 81 hospitals, 76 were screening newborns in 1999, resulting in 76% of all newborns being screened for congenital hearing loss. Among the 93 hospitals with newborn nursery care units in Iowa, the Universal Newborn Hearing Screening Program is currently underway in all Level III and in all but two Level II hospitals.

On March 30, 2000, the Maternal and Child Health Bureau, U.S. Department of Health and Human Services, Health Resources and Service Administration (HRSA) awarded a federal Maternal and Child Health Improvement Projects Grant to the state of Iowa. The award provides $100,000 each year for the four-year period of April 2000 through March 2004.

This grant was awarded to Child Health Specialty Clinics (CHSC), which will administer the grant, using CHSC regional clinics to assist with the system of newborn hearing screening and follow up in Iowa. The IDPH/FSB is working in collaboration with CHSC for the implementation of this grant in Iowa. The following seven goals have been identified:

- Provide newborn hearing screening services to all of Iowa's children and to develop a system to ensure early diagnosis of infant hearing loss.

- Develop a system of data management for newborn hearing screening results to obtain accurate state data regarding screening results, diagnostic follow-up, tracking, entry into early intervention, and linkage to a medical home.
- Develop a sustainable system of newborn hearing screening, follow-up, referral and tracking activities beyond the project period.
- Increase public awareness of the importance of good hearing to speech and language development and to increase public awareness of Iowa's newborn hearing screening program.
- Provide Iowa audiologists with the skills needed to serve infants with hearing loss.
- Coordinate results of and information from the newborn hearing screening identification system to other applicable state data systems.
- Establish a state Newborn Hearing Screening Advisory Committee.

Newborn Drug Testing. In July and August of 1998, the Council on Chemically Exposed Infants and Children of the Iowa Department of Public Health surveyed 123 Iowa hospitals and medical centers. The survey addressed existing practices among Iowa hospitals and physicians in the area of neonatal drug testing. Survey results indicated that 22% of those hospitals that delivered babies had a policy for testing newborns or delivering mothers for exposure to illicit drugs. None of the responding hospitals and medical centers had a policy requiring universal drug testing of all neonates. Recommendations resulting from the survey included the suggestion that the Council on Chemically Exposed Infants and Children may want to consider doing additional educational and informational work with hospitals and physicians in order to raise awareness of the issue of infants exposed to illicit drugs.

"Drug Use in Pregnancy: A Study of Prevalence in the State of Iowa" was published in July 1996. The study was conducted by the National Association of Families and Addiction Research and Education, and funded though IDPH and private contributors. The purpose of the study was to determine patterns of illicit substance use by pregnant women across the state of Iowa.

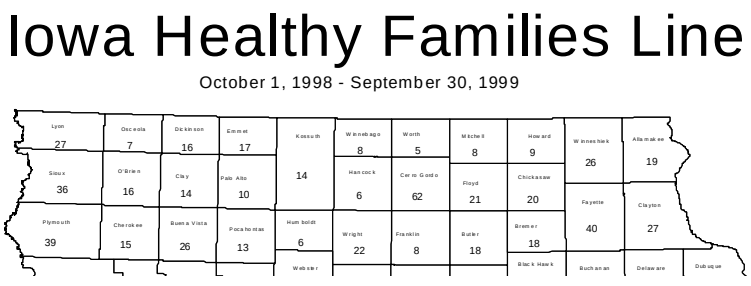
According to the study, "A total of 1,468 pregnant women had complete data collected as part of the prevalence study. Of the 1,422 pregnant women in the final sample, four percent had a positive urine toxicology for an illicit drug. Marijuana (3.1%), opiates (0.63%), cocaine (0.28%), and amphetamines (0.27%) were the illicit substances most commonly found among pregnant women in Iowa. Based on the estimated 37,418 deliveries in 1994 (Vital Statistics of Iowa, 1994: The Iowa Department of Public Health) and the prevalence data from this study, approximately 1,500 infants in the state are prenatally exposed to an illicit substance each year. This is a very conservative assessment, however, since these rates do not include women who received no prenatal care and do

not include evaluation for alcohol or tobacco use. By age, the prevalence rate for any illicit drug was highest among women ages 19-23 (6.9%), followed by women ages 24-27 (4.2%) and adolescents girls (2.6%). In the drug positive group, there were significantly more women receiving publicly financed health care (55%) than in the drug negative group (34%)."

The *Iowa Review of Family Assets.* The Iowa Department of Public Health conceived IRFA as a four year project, including two years of development and implementation. The project will provide the parents of a new baby the opportunity to assess their readiness for successfully rearing their new child. Based on a computerized self-assessment completed prior to hospital discharge, families will be provided with a family profile and with individualized information about resources in their community from which they might benefit. Families can learn about health care, childcare, social services, parenting education, and social support resources, and will be able to receive printed information as well. Jointly managed by the Iowa Hospital Association and the IDPH, the project will not only provide a direct service to families, raising the quality of obstetric discharge planning, but will also provide communities with previously unavailable information about the needs and resources of families in the state. In the future, the assessment will be available during the prenatal period, offering more comprehensive care to pregnant women.

Healthy Families Line

Iowa State University Extension Services and IDPH sponsor the Healthy Families Line. From October 1, 1998 to September 30, 1999 a total of 4,656 were received on the Healthy Families Line. A total of 1,933 (42%) of the calls were regarding the Care for Kids (EPSDT) Program, 1,039 (22%) concerning the state insurance program, 118 (3%) calls were placed on issues of dental health, 44 (1%) of the calls addressed prenatal issues, 26 (1%) concerning Healthy Child Care Iowa, and 19 of them discussing family planning issues. Another very important piece of the Healthy Families Line's report is 1912 (81%) of the callers were covered by Medicaid, with 12 callers concerned about the termination of Medicaid enrollment, and 261 (11%) of the callers had no insurance coverage. The following map shows the number of calls that were placed from each county and the number of out of state calls. The map shows no distinctive patterns or trends in the number of calls placed throughout Iowa's counties. More calls are being placed from the metropolitan areas compared to the rural area in the state. Healthy Families Line is capable of receiving more call than are being placed.



PREVENTIVE AND PRIMARY CARE SERVICES FOR CHILDREN

Immunization. During January-April, 1998, IDPH staff conducted the annual assessments of the public sector immunization providers in Iowa. There were 19,239 records reviewed. The assessment revealed that Iowa's public sector immunization providers continue to approach the goal of a 90% immunization level in children prior to their second birthday with an overall rate of 89%. Fifty-three public sector immunization clinics did attained 90% coverage levels.

The assessment also revealed that maintaining high levels of immunization coverage is as difficult as reaching those goals. The local infrastructure of immunization efforts continues to be challenged by the significant demands placed on these public sector providers. Many providers have reported a reduction of the time available to them to conduct routine recall activities because of increased demand for other public health services.

Injury Prevention. Injury prevention programs for children in Iowa have been successful at increasing age and size appropriate restraints in automobiles, bicycle helmet usage rates, and reducing the number of children injured or killed on farms. Iowa law requires that children under six be transported in an age/weight appropriate car safety seat or safety belt when transported in a motor vehicle. However, safety seat checkpoints conducted by department staff and others indicate that less than 10% of the safety seats are properly installed.

Staff member from FSB collaborate with the Governor's Traffic Safety Bureau on the Occupant Safety Advisory Committee for Children and Youth in Iowa. The name of the committee was changed from the Car Seat Task Force to reflect the change of focus to all children and youth vehicle related injuries and fatalities. This committee is comprised of representatives from various

statewide injury prevention agencies, community advocates, and advisory committees. A five-year strategic plan has been developed by the committee and was implemented in January of 2000. Progress made towards occupant protection initiatives has been possible due to the Governor's Traffic Safety Bureau, which supports a full time injury prevention specialist in the Bureau of EMS. This position coordinates efforts to provide communities with technical assistance regarding education and enforcement of child safety practices.

The IDPH also collects data on injuries to children occurring on farms, and brain or spinal cord injuries. Data show that children on farms most at risk are in the 0-4 and 15-19 age groups. The most common cause of fatalities is accidents with farm machinery. The youngest children are at risk due to their own curiosity and energy, the oldest due to inexperience and lack of knowledge in operating farm equipment.

Oral Health. Despite improvements in oral health over the past several decades, preventable oral disease still affects many children in Iowa. Among certain portions of the community, including children with special health care needs, those lacking access to preventive and routine care, those from families with lower income and education, and those from certain racial, ethnic and cultural groups, there is a higher amount of untreated disease as well as a higher prevalence of disease.

The Special Committee on Access to Dental Care submitted a report to the director of the IDPH in March 1998, concerning problems with access to dental care for Iowa residents. Since that time, a number of initiatives have been undertaken toward the improvement of access to dental care in Iowa, including the following.

- Comprehensive dental benefits were included in the initial HAWK-I benefit package (the State Child Health Insurance Program).
- A dental representative was accepted for the HAWK-I Clinical Advisory Committee.
- The state legislature appropriated an increase in funds for the dental Medicaid program, earmarked for primary and preventive services.

A statewide dental survey in 2000 showed that 41% of Iowa third graders did not have dental insurance. Another 14% had Medicaid or HAWK-I, and the remaining 45% had dental insurance. In the same age group, 10% went to the dentist more than three years ago or had never seen a dentist. The dental sealant rate in this age group is 38.9%. Children eligible for the free or reduced lunch program seemed to visit the dentist less frequently than those who were not eligible for the program. About 73% of third graders with dental insurance had visited their dentists within six months, plus another 19% had visited their dentist within 12 months. The children paid by Medicaid or HAWK-I also tended to visit the

dentist less frequently than children with dental insurance. This is likely due to less low income children having their own private dentist. The results of the dental survey are in Appendix K.

Nutrition. The Iowa Women Infants and Children's Supplemental Nutrition Program tracks nutritional status indicators for children through the Pediatric Nutrition Surveillance System (PEDNSS) through the Centers for Disease Control and Prevention. PEDNSS tracks the prevalence of children with easily measured nutritional status indicators who are less than the 5th percentile or greater than the 95th percentile. The indicators are low height for age, low weight for height, high weight for height, low birth weight, low hemoglobin, and low hematocrit.

Prevalence of high weight for height, or overweight, in children has increased from 7.6% in 1985 to 10.1% in 1999. This increase in the prevalence of overweight is consistent with the increase in other states reporting PEDNSS and national nutrition surveys conducted with school aged children. Because of the health implications of this risk factor, the IDPH has targeted this problem as a primary concern and will be developing strategies to address this issue.

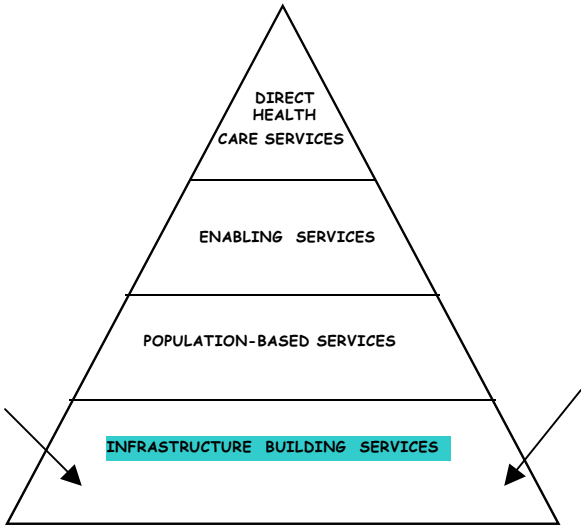
Children who are at risk for anemia are identified through a hematocrit or hemoglobin test at WIC clinics. The prevalence of low hemoglobin dropped after the first year of screening at clinics. The prevalence of low hemoglobin was 11.1% in 1999. Anemia and lead poisoning are often related. Many children in Iowa also are at risk for lead poisoning and the Child Health, WIC, and the Lead Poisoning Prevention program are working together to address these problems.

SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

A special CHSC staff retreat assembled for the FFY96 five-year planning cycle identified a need to improve follow-up rated for infants and children identified as high risk for future developmental delay. This year's assessment suggests the need persists. The term "high risk" is used to include: 1) those born with one or more clearly identified physiological criteria (the traditional high risk group systematically identified in newborn intensive care units); and 2) those experiencing potentially detrimental psychosocial circumstances (the so-called at risk group less systematically identified by a variety of early childhood and social service providers). Both groups, but especially the latter group, were noted by CHSC regional health service coordinators to be too frequently lost to follow-up. Lost to follow-up rates are approximately 20% for the traditional high risk group and indeterminately higher for the at-risk group. Low follow-up rates makes any needed early intervention services less likely to occur. Mounting interest by the IDEA Part C program to enroll all identified at-risk infants in the Part C Early ACCESS Program presents a new approach to

meeting and monitoring this priority need. Although not yet established, a proposed Early ACCESS database will provide a method to compare observed and expected enrollment numbers.

3.1.2.5 Infrastructure Building Services



This section addresses the priority state concerns for the Title V population groups as they relate to the infrastructure building services level of the MCH pyramid. For each of the three Title V population groups, subsections address concerns related to:

- existing systems
- collaborative mechanisms, and
- comprehensive systems of services.

PREVENTIVE AND PRIMARY CARE SERVICES FOR PREGNANT WOMEN, MOTHERS, INFANTS, AND CHILDREN

Health Provider Service Capacity Project. The Health Provider Service Capacity Project was designed to determine Iowa health provider's current and projected capacity to serve all children (ages 0-19) in Iowa. Because of new or changing programs in Iowa, more children (ages 0-19) have access to health insurance. The combined implications of expanded Medicaid, HAWK-I and Title V children transitioning from direct care services to care coordination services necessitated determining the capacity of Iowa providers. The project was a collaborative effort by the Family Services Bureau (IDPH), the Bureau of Nutrition and WIC (IDPH), Mid-Iowa Community Action (a regional community action program), and the Iowa Community Health Leadership Institute. The goal of the Iowa Community Health Leadership Institute is to offer an educational experience that

gives scholars new perspectives while developing a network of collaborative relationships at the local, state and national level.

A 30-item survey was mailed to 3,288 Iowa physicians in April 1999. This descriptive study looked at the scope of practice, patient load (Title V and Title XIX patients), staffing, service hours, referrals, services currently provided and to be implemented, barriers to providing services, and subcontracting considerations. Frequencies, percentages, and cross-tabulations were computed for each item. Regional analyses also were conducted. The following list includes some of the results of the survey.

- 1,193 health providers returned a survey for a response rate of 36.3%.
- 34.5% of respondents had knowledge of providing health services to Title V (Child Health) patients.
- 96.4% of respondents had knowledge of providing health services to Title XIX (Medicaid) patients.
- 83.7% of respondents could serve more children with current staffing.
- Respondents' primary reason for not being able to serve more children is not having enough medical and/or professional staff.
- 66.0% of respondents would consider expanding their practice to serve more children. However, 19.1% would increase budgets to meet this need.
- Services routinely provided for children by the respondents included well-child checkups, immunizations, school physicals, lead screens, and EPSDT.
- Services considered for subcontracting by respondents include speech, social and mental health, dental, and audiology/vision services.
- 62.1% of respondents made five or less referrals per week to public health agencies for child health services.
- 616 respondents reported making referrals to a WIC program.
- 420 respondents reported making referrals for immunizations.

The following list describes recommendations resulting from the survey.

- There needs to be stronger relationships between private providers and public health programs to assure the provision of comprehensive health services to all children in Iowa.

- Private providers could serve more children by hiring or subcontracting health professionals with previous experience in public health.
- An increase in promotion of public health programs for children would increase referrals from private providers for WIC, immunizations, lead screens, Early ACCESS, EPSDT, family planning, and maternal health services.

Evaluation of Early ACCESS System. In Iowa, the IDEA, Part C program of services to infants and toddlers with disabilities or delays and their families is called Early ACCESS. An evaluation of Early ACCESS was conducted from 1996 to 1999. Evaluators from the National Resource Center for Family Centered Practice at the University of Iowa collected data between 1997 and 1998, focusing on the state, regional, and individual client levels.

This evaluation of the Early ACCESS service system highlights Iowa's efforts to monitor the program effectiveness of the state's community-based service systems. The following list includes six key components that were determined to be factors in the effectiveness of the Early ACCESS program.

- interagency collaboration,
- family-centered service delivery,
- child-find effectiveness,
- the Individualized Family Service Plan (IFSP),
- utilization of available resources, and
- cultural responsiveness.

A perceived strength of this assessment was the associated collaborative effort of:

- Iowa Department of Education,
- Iowa Council for Early ACCESS,
- Child Health Specialty Clinics,
- Iowa Department of Public Health, and
- Iowa Department of Human Services.

However, ongoing usefulness of the evaluation is limited as the assessment becomes outdated and program changes occur within Early ACCESS. The Iowa Council for Early ACCESS is currently reviewing the study as it plans for future program evaluation efforts.

Maternal and Child Health Strategic Planning. Iowa continues work toward development of a comprehensive strategic plan that further defines the role of IDPH in the face of a changing health care and social environment. The growing importance of managed care arrangements and

the pressure to reduce the agency's role in providing direct service accentuate the need to reshape the future direction of MCH services in Iowa. FSB/CHSC leaders meet quarterly to move the planning process forward. The following key elements guide the strategic planning process:

- Adopt a focus on family quality of life;
- Market MCH strengths in coherent messages--become visible;
- Identify advocacy groups with which to affiliate and develop a plan to work with them;
- Create a vision and a set of indicators for the quality of life of Iowa's families; and
- Develop community-level interaction with the private sector.

Data Capacity Assessment/Inventory. Consultation regarding the development of a strategic plan for an Iowa MCH/CHSCN data system addressed the following tasks: 1) identify the initial steps that the FSB could take to utilize data more effectively; 2) identify strategies to apply like program data to other population data bases; and 3) provide recommendations for selecting performance measures. Following this technical assistance, the FSB has worked to implement the consultant recommendations:

- Expand access to and the analysis and dissemination of vital record data to increase the effective use of the data, boost interprogram relationships, and improve productivity; and
- Establish priorities in regards to upgrading their client-based data systems and developing population-based data sets.

A complementary data system inventory is also occurring at CHSC. With technical assistance provided by systems analysts from the University of Iowa College of Medicine, CHSC is seeking to upgrade their data system for more efficient data management and greater report generating capacity and flexibility. An in-house data-related "strategic initiative team" has formed to guide and facilitate the work of the technical assistance team. A major function of the strategic initiative team will be to carefully assess the current and future data needs of CHSC, both within the program and for wider system analysis and planning.

SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

A persisting need identified during the region-by-region focus groups and at the special CHSC staff retreat involves CHSC providers receiving incomplete medical record information from primary care referral sources. Most commonly this would be absent or incomplete growth charts, widely agreed upon as fundamental clinical data. This commonly observed missing data raised the more general question of quality of care. Therefore, a broader need was identified regarding quality improvement activities practiced in general medical care settings specifically applicable to pediatric patients with special health care needs. Attention to quality is ethically indisputable, but it has

gained notable emphasis as health care delivery becomes a more cost-conscious activity. For the five-year planning cycle beginning in FFY01, a new measurement instrument will be employed to monitor the performance measure corresponding to this identified need. At the same time, it is hoped that the measurement instrument itself will function as an educational medium for pediatric and family physicians.

Another persisting, even growing, need is to foster family participation in CHSC program and planning activities. The long-standing community-based parent-consultant network structure will be reviewed and rejuvenated. A rigorous, comprehensive, and collaborative evaluation is called for, followed by committed and resource supported program changes.

Two new infrastructure building needs emerged as part of the needs assessment process applicable to the next planning cycle. First, the Title V emphasis on infrastructure building has stimulated a recognized need for significant staff development and training. A combination of in-house sponsored experiences and external, more sophisticated, experiences are already being planned and executed. The combination of established clinical acumen and new skills in core public health functions among CHSC staff is expected to be effective in motivating service delivery system change and quality improvement. Second, the CHSC data system must be reviewed and revised. It is currently unwieldy and expensive, especially to generate special reports for purposes of program analysis and monitoring. Greater end-user flexibility and accessibility will be necessary for staff to be effective as they gain knowledge, skills, and experience with core public health functions.

Iowa Household Health Survey (applies to all three population groups). A major component of the five-year needs assessment is the Iowa Household Health Survey supported by an MCHB State Systems Development Initiative grant. The design of the population-based, random sample survey occurred during the first half of FFY00. The survey itself will be implemented in the second half of FFY00, while analysis of the survey will occur during the first half of FFY01. Finally, findings and recommendations will form a foundation for program planning in the second half of FFY01. The survey was conceptualized, designed, and piloted via a collaborative effort between the Title V MCH Program, the Title V CSHCN Program, and the University of Iowa Public Policy Center. The magnitude of the survey and care exerted in its design means that results will not be available to include in this application submission. However, an updated interim needs assessment will be submitted in the FFY02 application and, if indicated by survey results, updated statewide priority needs and corresponding performance measures will also be offered.

The survey will be performed through structured interviews on a randomly selected sample of 3,600 Iowa families with children ≤ 21 years old. The state will be divided into eight geographic areas that are hypothesized to be different from one another based on median income, population density, service provider availability and distribution, and historic clustering of counties and other service units. The geographic areas will be composed of six multi-county regions and two large and densely populated individual counties.

In addition to 3,600 telephone surveys, which include an oversampling of minorities and children with special health care needs, 400 face-to-face interviews will be performed with families who do not have phones. They are considered a group worthy of analysis due to income status and resource needs. Thus, the survey is designed to allow statistically valid inferences about families without telephones, families from different geographic regions, families of children with special health care needs, and families who are racial or ethnic minorities.

The survey content was adapted from a variety of established and validated survey instruments, most prominently the "HAWK-I Child Health Insurance Program Survey" used to evaluate the Iowa SCHIP; and "Survey of Medicaid SSI Enrollees" used to assess families' experiences with the SSI Program. The Household Health Survey consists of questions inquiring about demographics, diagnostic and functional health status, health service utilization (including mental health and oral health services), insurance status, school performance and activities, family activities and dynamics (including socialization, stress, and child care), and screening questions (adopted from the Foundation for Accountability) to identify children with special health care needs. An additional subset of questions is asked of families who have a child with special health care needs.

Analysis of information collected will be used to estimate the health and health care service needs of children and families in Iowa. Survey results will be used to identify differences in need according to regional variations, demographics, and family characteristics. Special emphasis will be given to analysis of racial and ethnic health disparities, and issues for children with special health care needs. Results also will be used to obtain data for selected national and state performance measures, as well as for possible resetting of performance objective values based on improved estimation methods.

Beyond the originally proposed survey design and analysis, there will be an opportunity for smaller sized geographic areas to request and pay for additional local surveys. This oversampling will allow valid statistical inferences to be made with respect to the specific local community. As of this time, several communities and smaller county clusters have expressed interest in this service.

Survey results will be shared with and interpreted by Title V staff in collaboration with the State MCH Advisory Council. The Council will recommend further avenues of dissemination, as well as highlight survey details potentially useful for state and local planning. The survey may serve as a basis for statewide policy recommendations and legislative initiatives. It will be shared with local public health departments, boards, and other public agencies (e.g. human services, education, mental health, and juvenile justice) with the expectation that it be used for local planning and policy development.

3.2 Health Status Indicators

3.2.1 Priority Needs

See Form 14

A needs assessment has been completed to guide the identification of Title V state-specific priority needs for the five-year period, FFY01-FFY05. The needs assessment methods and results are described in section 3.1.1. The needs assessment, in combination with the MCH Health Status Indicators, provides a rational basis for the selection of priority needs. Needs suggested by the assessment beyond the ten listed in Form 14 are included in other program planning documents.

Priority needs were identified in each of the four pyramid levels. All three of the population groups are covered by the following state-specific priority needs.

Direct Health Care and Enabling Services:

Establish an integrated system of comprehensive mental health services for children in Iowa. In CHSC's "Problem Prioritization Process", number one of 29 ranked problem areas was the provision of needed mental and behavioral health services by providers specializing in child and adolescent mental and behavioral health. Supporting the need was a 7th place ranking assigned to the goal of implementing a comprehensive community-based system of services for all Iowans with a mental illness or disorder.

Assure quality services for children with special health care needs enrolled in managed care plans. This quality-related problem received a midlevel ranking in the CHSC "Problem Prioritization Process". However, because of persistent and growing concern for issues of quality, especially regarding CSHCN enrolled in managed care plans, this problem received special priority. This concern is further supported by results of the CHSC "Family Need and Satisfaction Survey" showing a relationship between quality and satisfaction. Also contributing to the high priority are the growing collaboration and mutual concerns of the Iowa Department of Human Services and

CHSC.

Assure continuity of health care and related services for pregnant women and children ages 0-21. A review of submitted individual county needs assessments revealed a collective top priority of "access to continuous services for women of childbearing age and children from birth to adulthood". This priority need is related to and consistent with the national priority need for all children with special health care needs to have a medical/health home.

Assure access to dental treatment services for children in Iowa. The problem of access to dental treatment has been a persistent problem in Iowa as evidenced by a 4th place "Problem Prioritization Process" ranking by Family Services Bureau staff and a 1st place ranking by a wide array of MCH stakeholders attending the annual State MCH conference. Developmental Health Status Indicator #4 supports access to dental treatment being a priority problem.

Population-Based Services:

Increase participation of infants in programs that provide monitoring and follow-up for the at risk population. Improving follow-up programs for at risk infants attained a 2nd place ranking in CHSC's "Problem Prioritization Process". This problem area remains significant because of the extreme importance of early intervention for children with developmental delay and the continuing fragmentation of early identification and follow-up programs.

Reduce health disparities among pregnant women and children. This continuing national priority need was ranked among the top six problem areas facing Iowa's MCH target population. The significant racial disparities in Iowa for low birth weight and infant mortality in the face of relatively low overall low birth weight and infant mortality rates suggests this is a priority need.

Improve the fitness of children. This priority need is a modified continuation of the priority need from the last planning cycle that sought to "improve community capacity to serve children with obesity." Although ranked 13th of 14 problem areas, further discussion among staff interpreted the ranking as a reflection of intervention difficulty and not public health importance. Dedication to the importance of public health involvement and a focus on fitness elevated this problem's priority.

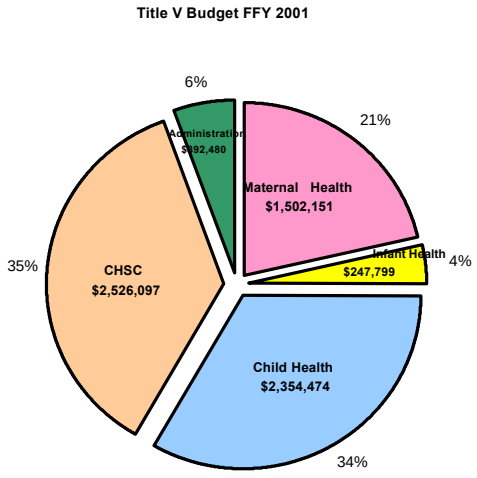
Infrastructure Building:

Enhance data collection, management, analysis, and utilization to support identification and investigation of health problems affecting women, children, and families. Scores on the Core Health Status Indicator #8 and the CHSC "Strategic Direction Assessment Process" elevated this problem area to the level of a priority need. A similar priority need was in force during the last planning cycle; however, insufficient progress was made toward the goal. Data capabilities remain essential for rational program planning, documentation, and accountability.

Improve the preparation of families to meet the physical, emotional, and social needs of their children. The MCH stakeholders attending the year 2000 annual State MCH conference ranked parent readiness as the 3rd most pressing priority for the MCH target population. This ranking has

been consistent over the several years that this particular assessment method has been employed. Increase development and use of quality improvement strategies applicable to general medical care of pediatric patients with special health care needs. In the CHSC "Problem Prioritization Process", this problem area was ranked at the midpoint of the 29 item problem list. However, subsequent group planning discussions elevated the priority for the reason of a well-begun, but incomplete intervention for this problem. Also, quality issues pertaining to CSHCN have been consistently gaining importance at national and state levels. Finally, the CHSC "Family Needs Satisfaction Survey" highlights the relationships of service quality and family satisfaction with health services, especially in the circumstances of severely affected children or low family income.

3.3 Annual Budget And Budget Justification



The FFY2001 Title V appropriation is projected to be $7,022,990. A total of 2,602,261 (37%) is budgeted for preventive and primary care for children; $2,526,097 (36%) for children with special health care needs; and $392,480 (5.6%) for program administration. Each of these budgeted items satisfies federal legislative requirements. Figure A illustrates the budget plan for the FFY 2001 Title V allocation.

3.3.1 Completion of Budget Forms

See forms 2, 3, 4 and 5 in supporting documents and Appendix O.

3.3.2 Other Requirements

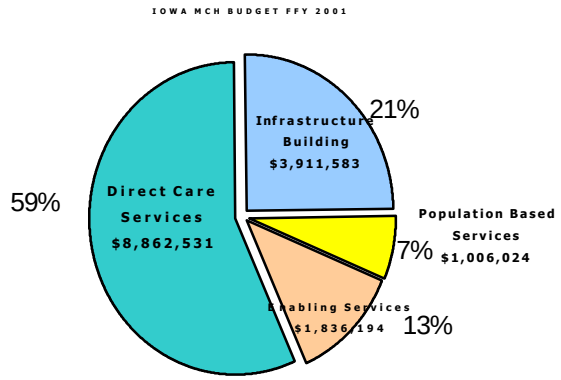
Iowa continues to exceed the state maintenance of effort from 1989 of $5,035,775. The FFY2001 budget is based on a federal allocation of $7,022,990. The projected state funds exceed the required match and maintenance of effort.

Iowa strives to maintain a carryover balance to avoid interruptions in essential services that could occur in the event of an unanticipated delay in funding. The current level of carryover is $979,297.

Direct Services. The federal state partnership expenditures for continuation of direct care services are estimated at $8,862,531. This represents approximately 57% of the partnership budget. The amount includes funding for community based maternal health and child health agencies. This category includes HOPES Home Visiting; Birth Defects Institute and Regional Genetics Services; the Physicians' Care for Children program; dental treatment and dental sealant pilot projects; SIDS autopsies; the repetitive prematurity prevention project; and the OB indigent program. CHSC projects a budget of $2,756,680 or approximately 50.6% of the CSHCN budget. Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in the amount listed for the categories that follow.

Enabling Services. This category includes the Healthy Families toll free information and referral line, the Teen Line, a statewide newsletter for EPSDT providers. It also includes approximately 28.9% of the CSHC funding, or $1,574,541. The amount of budget for Enabling Services is $1,836,194 (12%).

Population Based Services. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. Iowa anticipates expenditures of $1,006,024which represents seven percent (6%) of the total budget. IDPH projects expenditure of $696,005 (plus the related administrative costs), and CHSC projects a budget of $275,466 or approximately 5% of the CSHCN budget.



Infrastructure Building Services. Estimated expenditures for continuing development of core public health functions and system development are $3,911,582 or 25% of the total federal state partnership budget. This amount includes support services and salaries for maternal health, child health and EPSDT, and the Council on Chemically Exposed Infants and Children. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities and child

health systems development consultation. CHSC's budget for infrastructure building services is estimated at $832,839 (15.3%). Appendix O provides a detailed list of programs by category.

The total budget for the federal state partnership is projected to be $15,616,331. Figure B shows the allocation of funds by level of service for the total budget.

Other federal funds directed toward MCH include a Special Project of Regional and National Significance (Healthy and Ready to Work); the State Systems Development Initiative; two Community Integrated Service System projects (Community Organization Grant and Healthy Child Care); Abstinence Education Initiative; Early Intervention Services (IDEA - Part C); Title X Family Planning; Newborn Hearing Screening grant; Genetics Data Enhancement; and DHS funded Healthy Child Care Iowa . Iowa 's CISS - Community Organization grant ($50,000) is central to efforts for developing leadership and advocacy in child health at the community level. The CISS Healthy Child Care initiative is funded at $72,500. The MCH programs will not receive transfers from the Prevention Block grant in FFY01; this is a change was initiated by the department in FFY1999. Other federal MCH Related funds total $1,726,176.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

3.4.1.1 Five Year Performance Targets

See Form 11

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

See Form 11 and Form 16

3.4.2.2 Discussion of State Performance Measures

Each of the Iowa Title V performance measures is related to a priority need determined by one or more needs assessment procedures outlined in section 3.2.1. The measures themselves are clearly not the only measures that could have been selected to assess progress towards meeting each particular need. Performance measures adhere to the "Criteria for Selecting MCH Measures and Indicators (MCHB/OSCH, 10/97)" in the Training Materials for the MCH Services Title V Block Grant Program (11/5/97). Each performance measure is linked to the desired outcome, and improvement in the measure indicates progress towards meeting the priority need.

Proposed program activities related to a performance measure (see section 4.1) may be wider in scope than the particular performance measure. This reiterates the statement above – that there is more than one performance measure that could relate to a given priority need. It is assumed that if there is improvement in the selected performance measure, there would likely be improvement in other related, but not selected, performance measures.

The rationale for selecting each performance measure can be found in the "Significance" statements accompanying each specific state performance measure described on Form 16. Additional rationale is provided above in needs assessment sections 3.1.2.2 – 3.1.2.5, where the needs assessment and results are discussed by MCH pyramid level and target population group.

Some degree of linkage between selected performance measures and outcome measures is presumed. Improvement in performance measures depends on improvement in capacity, process, or risk factors; in other words, changes in the health care delivery system and in the health behaviors of target populations. Since improved health outcomes depend on many, often interrelated, factors, it is not possible to attribute improvement entirely to Title V program activities.

3.4.2.3 Five Year Performance Targets

See Form 11

3.4.2.4 Review of State Performance Measures

Not applicable.

3.4.3 Outcome Measures

See Form 12

4.1 Program Activities Related To Performance Measures

Forecasting for Performance and Outcome Measures. In arriving at realistic outcome goals, every effort was made to objectively and accurately select achievable results. In general, prior experience is the most reliable predictor of future progress on goals. Objectives for outcome measures, for which historical data exists, were arrived at by applying a mathematical formula as a method of forecasting. While this method is mechanical, it offers an objective predictive approach, reflecting experience. When historical data were not available, other predictive approaches were

used. Program experts made estimates of the progress that could be expected in one year increments over five year time periods.

The following describes the methods used to arrive at projections for outcome objectives for which historical data were available. First, a three-year moving average was computed using the most recent five to seven years rates. One year overlap is used for each term: (years 1,2 and 3)/3, (years 2,3 and 4)/3, (years 3,4 and 5)/3, etc. until the most recent year is included. Because actual vital statistics vary from year to year, the moving average is used to stabilize and smooth the data trend before forecasting the coming years' annual outcome objectives.

Second, the average annual percent change (decrease or increase) is based on the following formula, where n is the total number of plots of the moving average curve. The "*Rate* in *Year i* " is actually the mean value of a given three-year period, and the "*Rate* in *Year i-1*" is a value of the previous three-year average.

$$\frac{\left(\sum_{i=2}^{n}\frac{Rate_{year_i}}{Rate_{Year_{i-1}}}-1\right)\text{x}100}{n-1}$$

Third, the following formula is applied to project the new rate. This is accomplished through linear extrapolation, which interactively increases or decreases the number or rate according to the average annual percent change. For example:

- Projected rate (1996-98)=mean 1995-97 rate + average annual % change * mean 1995-97 rate.
- Projected rate (1997-99)=mean 1996-98 rate + average annual % change * mean 1996-98 rate.

This process provides a possible range of the future years instead of exact numbers. Change of some objectives cannot be expected to occur at the same speed in the future as in the past. Therefore, small adjustment might have to be made to the calculated numbers. The same numbers for the conjunct year mean that there is no big change is expected during this period.
This method has been used for outcome measures 01, 03, 04, 05, 06 and performance measures 05, 06, 07, 08, 09, 15, 16.

If less than three years historical data were available or if the trend goes to the opposite direction from expectations, program experts made estimates based on the ongoing program or proposed goals. This method applied to outcome measures 02 and for performance measures 01, 02, 03, 04, 10, 11, 12, 13, 14, 17, 18, as well as all ten state selected measures.

While efforts are made to project performance objectives with some precision, it is recognized that

all intervening variables cannot be accounted for through use of expert opinion or a forecasting formula. Some data out date much slower than other data sets, such as numbers of children living in poverty, as well as being out of control of our projections. It is hoped that our various monitoring methods will continue to improve the value of our data system as well as our outcomes.

01
National Performance Measure

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Care Needs (CSHCN) Program.

Type: Capacity
Category: Direct Health Care

Program Activities Related to Performance Measures
HI2010
6.33 Goal Statement: Develop a statewide, consumer-controlled Personal Assistance Service (PAS) program available to all Iowans with disabilities who need it.

Relationship to Priority Needs
Under OBRA '98 legislation, Title V programs are charged with providing rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI to the extent medical assistance for such services is not provided under Title XIX.

Capacity/Resource Capability
The Iowa Child Health Specialty Clinics has a designated Title V-SSI liaison dedicated to maintaining information on both SSI eligible and ineligible children as referred by the state Disability Determination Services Bureau (DDSB). These children are entered into the program database using specific coding procedures. A formal agreement with the Department of Education (parent agency to the DDSB) sets forth outreach and information sharing responsibilities. An Iowa SSI Collaborative Agency Committee exists to coordinate statewide SSI outreach efforts.

Program Activities

Assessment
- Collaborate with DSH to determine services required by SSI-eligible children that are not funded under Title XIX.
- Revive the Iowa SSI Collaborative Agency Committee to review the status and needs of SSI beneficiaries served within the state system of services for CSHCN.

Policy Development
- Request exception to policy for necessary rehabilitative services not covered by Title XIX.

Assurance
- Maintain current communication and information flow with relevant federal, state, and community agencies with respect to the SSI Program
- Continue to update CHSC staff and other health professionals who then share with local community agencies.
- Inform families of children who are denied SSI eligibility about the appeal process, the services CHSC provides, and other services available in the community.
- In collaboration with the Iowa Department of Human Services (DHS), continue to encourage SSI-eligible families to apply for Title XIX benefits for which they are automatically eligible.

02

National Performance Measure	The degree to which the state Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Type: Capacity
Category: Direct Health Services

4.1 Program Activities Related to Performance Measures

HI2010
6.30 Goal Statement: Persons with disabilities understand the health and other benefits of AT, how to select and obtain it, and have access to information about the health-related funding sources for AT.

Relationship to Priority Needs
Under OBRA '89 legislation, Title V programs are charged with providing and promoting family-centered, community-based, coordinated care (including care coordination services) for CSHCN and to facilitate the development of community-based systems of services for such children and their families.

Capacity/Resource Capability
CHSC is the program designated in Iowa to carry out services authorized under Title V of the Social Security Act. To this end, CHSC maintains a statewide system of regional child health centers and a central administrative office. A cadre of permanent and contracted staff are trained to provide a wide variety of direct health care, care coordination, family support, and professional training and consultation services. Collaboration and information sharing with relevant state and community organizations establishes CHSC as a specialty service provider for families who are low income or otherwise have no access to like services.

Program Activities

Assessment
- Monitor service system to assess if services not paid for by CHSC are otherwise provided and accessible to CSHCN.
- Perform provider/family sample surveys to determine if the service system is generally meeting families' service needs.
- Incorporate inquiries regarding specialty service accessibility and availability into FFY00 statewide needs assessment survey.

Policy Development
- Continue and expand advocacy and planning activities directed at helping families obtain services in a community-based, family-centered, coordinated fashion.

Assurance
- Track instances where accessible services are not being provided by any service provider.

03

National Performance Measure The percent of Children with Special Health Care Needs (CSHCN) in the state who have a "medical/health home."

Type: Capacity
Category: Enabling Services

4.1 Program Activities Related to Performance Measures

HI2010
11.9 Goal Statement: Increase to 91% the percent of all children in Iowa, including those with special health care needs, who have a medical and/or health home as defined by the American Academy of Pediatrics.

Relationship to Priority Needs
It is generally agreed that care for CSHCN may be complex and requires significant continuity and breadth of service. The idea of "medical/health home" suggests a service delivery site and staff familiar with the circumstances of child and family. From this "home," an array of comprehensive, coordinated, and family-centered services can be offered to the effect of improved outcomes.

Capacity/Resource Capability
CHSC maintains a system of 13 regional child health centers located within an hour's drive of almost all families in the State. CHSC regional staff develop professional relationships with a wide variety of community providers in health, education, and human services. These formal and informal relationships create a foundation for establishing medical/health homes for all CSHCN. Urban areas with higher populations will be more challenging due to greater provider availability with correspondingly less coordination.

Program Activities

Assessment
- Collaborate with the University of Iowa Public Policy Center to develop survey instrument(s) for providers and consumers using criteria suggested in the definition of medical/health home.
- Assess the status of families receiving CHSC services with respect to their having a medical/health home as a pilot survey.
- Utilize the Title V Iowa 5-year needs assessment household survey as a vehicle for assessing medical/health home status of all CSHCN in Iowa.

Policy Development
- Collaborate with the Iowa Department of Public Health regarding an agreed upon operational definition of "medical/health home", favoring use of some or all criteria of the American Academy of Pediatrics definition.

Assurance
- Use assessment results as a basis for planning to increase the percentage of CSHCN who meet or closely meet the accepted definition of having a medical/health home.

04
National Performance Measure

Percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).

Type: Risk Factor
Category: Population Based Services

4.1 Program Activities Related to Performance Measures

HI2010
11.1.4 Action Step Statement (under the goal to reduce infant mortality): Continue to assure availability of a metabolic newborn screening panel to every infant born in Iowa.

Relationship to Priority Needs
This MCH performance measure does not have a clear relationship to the ten Iowa MCH Priority Needs. However, in a less direct way, completion of activities related to the program contributes to meeting the Iowa Priority Needs, including care coordination services (SPN #6), access to care (SPN #3), development of data systems (SPN #8), and ensuring that all infants receive appropriate follow-up care (SPN #7).

Capacity/Resource Capability
In partnership with the University of Iowa and health care providers throughout the state, IDPH has developed programs that provide Iowans with state of the art genetics health care. Newborn metabolic screening tests are analyzed by the University of Iowa State Hygienic Lab, and the University of Iowa Department of Pediatrics provides comprehensive follow-up care. The Birth Defects Institute provides oversight for the program.

Program Activities

Assessment
- Develop a state genetics plan, including a newborn screening program component.
- Develop a system for matching the electronic birth certificate and newborn screening collection form.
- Investigate the need for the IDPH to assume a more active role in short-term follow-up and educational activities of the screening program.

Policy Development
- Convene the Birth Defects Advisory Committee four times per year to discuss issues related to the newborn screening program and to make recommendations to the IDPH.
- Actively promote national efforts to develop newborn screening policies and standards of care.
- Investigate the possibility of including additional disorders in the screening panel.
- Develop policies, as necessary, to improve the functioning of the newborn screening program.

Assurance
- Provide technical assistance and oversight to the newborn screening personnel to ensure ongoing follow-up activities are completed in a timely manner.
- Monitor the development of the newborn screening electronic result reporting system.
- Assure availability of metabolic newborn screening to every infant born in Iowa.

- Assure that every child who is confirmed positive with one of the disorders receives medical food as needed through the Iowa metabolic formula program.
- Provide interpreting and translating services to those families who need assistance.
- Provide consultation and educational services by follow-up personnel to local school systems, community groups and health care agencies as needed.
- Provide care coordination activities for infants, children and families identified by the newborn screening program through local agencies, including WIC, public health nursing, and area education agencies.
- Provide consultation assistance to local attending physicians and other health care providers through University of Iowa consultants.
- Advocate for the families with insurance companies, the state Medicaid system and other fiscal agencies.
- Contract with the University of Iowa (Department of Pediatrics) for highly specialized care for children identified by the newborn screening program.
- Utilize recommendations from the National Newborn Screening and Genetic Resource Center site review to improve services and functioning of the program.

05
National Performance Measure

Percent of children through age two who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus, Influenza, Hepatitis B.

Type: Risk Factor
Category: Population Based Services

4.1 Program Activities Related to Performance Measures

HI2010
14.1 Goal Statement: Reduce indigenous cases of vaccine-preventable disease by 50% by the year 2010.

Relationship to Priority Needs
IDPH plans to improve efforts to reach minority groups and educate parents, providers and the general public about immunizations in order to reduce health disparities among infants. (SPN #3)

Currently immunization data are limited to public clinics and CDC survey data. A plan will be implemented to increase knowledge of the immunization status of children at the local level through data downloads from the DHS fiscal agent on a quarterly basis. This will allow the local agencies, which will be utilizing the Iowa Department of Public Health's Child Health database to do care coordination in order to enhance the immunization status of their clients. In addition, as physicians initiate the electronic immunization tracking system into their practices, population data should be available for statewide monitoring of rates, which will more accurately reflect all Iowa children's immunization status. (SPN #10)

Capacity/Resource Capability
The Title V staff provide technical assistance in the development and analysis of a survey of immunization rates of two year old children on Medicaid and in the development of a plan to follow-up on children not immunized. This plan will build on the well-developed infrastructure throughout the state of EPSDT care coordinators and public health nurses. The state of Iowa has developed and implemented an electronic immunization tracking system in the public sector which will be broadened to the private sector over this coming year. Title V staff work with the Bureau of Immunization on this project. In addition, the Department of Human Services collaborates with the department to better utilize the Medicaid claims data in an effort to better identify under immunized children.

Program Activities

Assessment
- Explore alternative strategies to increase access to immunizations for hard to reach populations.
- Review immunization data of two year olds for patterns and trends in public health and child health clinics.
- Develop a mechanism to import claims data into the child health software program on a regular basis.
- Develop a mechanism to import data from the immunization registry into the child health software on a regular basis.

Policy Development

- Advocate for public agencies to be recognized as providers for private insurance and managed care.
- Encourage local communities and contract agencies to promote immunizations through the media.
- Provide technical assistance to communities with immunization rates below the state average.
- Promote continuity of care between and among service delivery systems.

Assurance

- Continue to provide information and referral through 1-800 Healthy Families line.
- Collaborate with the IDPH Bureau of Immunization to work more closely with private providers to improve the immunization compliance rates in their practices.
- Increase access to immunizations through review of records by health care providers while providing services at WIC, Title V child health and public health clinics.
- Design and implement a care coordination plan focused on compliance with immunization recommendations for 18-month-olds enrolled in Medicaid.
- Provide assistance to eight WIC agencies receiving immunization grants to assure children on the WIC program are fully immunized.

06
National Performance Measure

The birth rate (per 1,000) for teenagers aged 15 through 17 years.

Type: Risk Factor
Category: Population Based Services

4.1 Program Activities Related to Performance Measures

HI2010
7.1 Goal Statement: Increase to at least 63 percent the proportion of pregnancies among Iowa women aged 15-44 that are intended.

7.2 Goal Statement: (Developmental) Reduce pregnancies among females between the ages of 15-17 by five percent per 1,000 females and to eliminate pregnancies of females between the ages of 12 to 14.

7.3 Goal Statement: Increase to at least 62 percent the proportion of persons grades 9-12 who have not had sexual intercourse.

Relationship to Priority Needs
Maternal health centers and family planning agencies continue to reduce health disparities for young pregnant women and their infants. (SPM #3)

Capacity/Resource Capability
Select Title V contract agencies continue multi-program contracts to include maternal health prenatal services and family planning services. Those agencies strive to develop strategies to reach and educate adolescents through programs and referrals to programs such as abstinence education, school based youth services, Teen Line, etc.

Program Activities

Assessment
- Distribute materials promoting the use of the Title V supported toll free Teen Line and Healthy Families Line. TTY numbers are provided for these lines.

Policy Development
- Promote collaboration at community level for teen pregnancy prevention activities (ISU Extension programs, DHS pregnancy prevention, parenting education, family planning outreach, family support).
- Promote communication between maternal health centers and other local agencies to optimize client access to need based comprehensive services (HOPES, family planning, alternative schools, school based youth services).
- Promote asset development in youth through strategies including workshops, informational programs, peer counseling, mentoring, media development, and curriculum development.
- Foster coordination and collaboration within communities to focus on abstinence from sexual activity before marriage.

Assurance

- Continue Title X family planning services in all Iowa counties (between the two Title X contractors in Iowa).
- Continue outreach to adolescents by Title X contract agencies, and school based youth services programs.
- Continue the abstinence education initiative which includes the involvement of Title V contract maternal health agencies.

07
National Performance Measure

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Type: Risk Factor
Category Population Based Services

4.1 Program Activities Related to Performance Measures

HI2010
15.7 Goal Statement: Increase to at least 70 percent the proportion of children in the third grade who have received protective sealants in permanent molar teeth by the year 2010.

Relationship to Priority Needs
Dental access for low-income families continues to be a problem in Iowa. A survey of third grade children was conducted in the spring of 2000 to determine the prevalence of dental sealants in third grade children. Data from that survey indicated that nearly 41 percent of children in third grade had at least one sealant on a permanent molar tooth.

Capacity/Resource Capability
A survey of third grade children was conducted in the spring of 2000 to determine the prevalence of dental sealants in third grade children. Data from that survey indicated that nearly 41 % of children in third grade had at least one sealant on a permanent molar tooth.

Program Activities

Assessment
- During the spring of 2001 the Dental Health Bureau will utilize dental hygienists through the child health agencies to conduct an oral health survey of school children in Iowa. Data will be collected on the prevalence at least one sealant on a permanent molar tooth.

Policy Development
- Ten percent of the dental treatment funds allocated to each child health center in Iowa for FFY2001 will be set aside for reimbursement for dental sealants.
- Reinforce the importance of dental sealants through child health agency's dental hygienists and nurses, stressing the benefits of sealants through education to the parents.

Assurance
- Seal Iowa materials continue to be available upon request from the child health agencies. The Seal Iowa program educates consumers, especially parents of young children, on the benefits of dental sealants. The program will also continue to promote the increased utilization of dental sealants by dentists.

08
National Performance Measure

The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,00 children.

Type: Risk Factor
Category: Population Based Services

Program Activities Related to Performance Measures

HI2010
HI 2010 Goal 15-9: Reduce deaths caused by motor vehicle crashes to no more than 1.3 per 100 million vehicle miles traveled and 15.5 per 100,000 people with special attention to children age 14 and younger, youth age 15-24, and people aged 75 and older as indicated in the following table:

Special Population Targets
Deaths Caused by Motor

	Baseline 1994	2010 Target	% Change
Vehicle Crashes (per 100,000)			
a. Children aged 14 and younger	6.3	5.6	11%
b. Youth aged 15-24	33.6	30.0	10%
c. People aged 75 and older	21.1	18.8	11%

Relationship to Priority Needs
No state priority need directly relates to this national performance measure.

Capacity/Resource Capability
Title V child health programs provide anticipatory guidance on developmentally appropriate safety topics as a part of well child preventive visits.

Program Activities

Assessment
- Work to increase correct safety seat usage for infants and toddlers in targeted communities.
- Monitor morbidity data relating to unintentional injuries to children by review of vital statistics and Emergency Medical Services for Children data.
- Review and disseminate seatbelt and car seat utilization data collected by the National Highway Traffic Safety Council.

Policy Development
- Collaborate with the Injury Prevention Coalition (representing the Governor's Traffic Safety Bureau, the Iowa Department of Public Health, and the University of Iowa) to accomplish the following.
- Collaborate in law enforcement activities promoting public information and education on pedestrian and bike safety for school children (K through 12).
- Assist in state patrol efforts to educate middle school children on seat belt, impaired driving, bicycles, school crossing, and bus safety in all 99 counties.
- Encourage local police departments to provide drug abuse education and other anti-drug programs in schools.
- Educate judicial representatives about occupant safety to support aggressive adjudication of cases involving infractions.

- Educate public policy makers on need for helmet use when riding bicycles.
- Explore strategies to increase the number of communities initiating the Safe Communities multidiscipline community based approach to injury reduction.
- Encourage expansion of Ride Right programs through strategies to involve health professionals, engineers, and emergency response personnel.
- Educate public policy makers about the need for child occupant protection in every sitting position in the car for children birth to 16 years.

Assurance

- Increase bicycle helmet usage by kindergarten through 14 year olds in targeted communities.
- Provide multilingual information and education that addresses the criteria of an unsafe seat.
- Develop a regional network to disseminate information and provide access to equipment for the transportation of children with special health care needs.
- Develop a mechanism to disseminate occupant safety information.

09
National Performance Measure

Percentage of mothers who breastfeed their infants at hospital discharge.

Type: Risk Factor
Category Population Based Services

4.1 Program Activities Related to Performance Measures

HI2010
13.2 Goal Statement: By 2010, 75 percent of infants will be breastfed at birth; 35 percent until six months old; and 15 percent breastfed until 12 months old.

Relationship to Priority Needs
Although breastfeeding did not appear this year as a top ten priority, in previous years this objective was identified as a priority. Strategies developed in 1996 continue as an activity in the state plan.

Capacity/Resource Capability
The Title V program continues in the collaboration with WIC and local community based breastfeeding coalitions to promote the importance of breastfeeding. Breastfeeding initiatives are incorporated in community maternal health center services.

Program Activities

Assessment
- Collaborate with Bureau of Nutrition and WIC to utilize Pediatric Nutrition Surveillance Data Systems and Pregnancy Nutrition Surveillance Data Systems.
- Monitor data collected through the University of Iowa Hygienic Lab.

Policy Development
- Coordinate the WIC agencies and the 26 Title V maternal health centers in several activities, including the promotion of breastfeeding by new mothers.
- Continue to support the availability of technical assistance on breastfeeding from the Nutrition Program for local MH and WIC programs and community-based coalitions.
- Collaborate with the Bureau of Nutrition and WIC to work on policy changes evolving through data and data trends.
- Support local agencies in implementing breastfeeding coalition recommendations.

Assurance
- Continue the statewide distribution of breastfeeding education materials.
- Continue "care coordination" activities of MHCs, including coordination /collaboration with the WIC program, particularly to the population at risk (e.g., language barriers, low income, etc.)
- Continue implementation of Best Start breast feeding promotional that began in FFY97.
- Hold conference and workshops on breastfeeding to provide CEU and training opportunities for state and local agency staff.
- Continue as co-sponsor of annual breastfeeding workshops and provide technical assistance to breastfeeding coalitions in the state.

- Provide representation on the State breastfeeding coalition.

10
National Performance Measure

Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Type: Risk Factor
Category: Population Based Services

4.1 Program Activities Related to Performance Measures

HI2010
11.4 Goal Statement: Increase to 94% the percentage of newborns who are screened for hearing impairment before hospital discharge.

Relationship to Priority Needs
Infants identified as having a hearing loss would benefit from quality measures for pediatric patients with special health care needs. (SPN #5) Hearing impaired infants may also be high risk and benefit from follow up as available from CHSC, Title V Child health clinic staff in limited areas, AEA audiologist and other private community audiologists. (SPN #7) Other capacity is enhanced through the development of a data system related to the electronic birth certificate (vital records) and a data management and tracking system for use by hospitals, area education agencies, and others involved with follow-up activities. This state wide data management and tracking system will be housed at University Hospital School. (SPN #10)

Capacity/Resource Capability
Iowa hospitals with newborn hearing screening services are working collaboratively with Area Education Agency (AEA) audiology personnel and many private audiologists. Through collaborative efforts with IDEA Part C funds, a 28 E Agreement exists between the IDPH and University Hospital School in Iowa City for the implementation of this performance measure. Newborn hearing screening will be universal in Iowa by 2000. As of April 2000, 79 Iowa hospitals are screening and they account for 97% of all Iowa births. No plan exists to implement mandatory screening.

Title V agencies will expand their role to assist in meeting the annual targets for this performance measure. Information will be shared with Title V agencies so they can assist with follow-up to assure a continuum of care for those infants who are identified as having a hearing impairment.

Program Activities

Assessment
- A data management system for early hearing detection and intervention among hospitals, area education agencies, and the Iowa Department of Public Health has been outlined and initial implementation steps will be coordinated by University Hospital School. Many AEA's are utilizing this data management and tracking system. Hospitals are waiting for assistance with this system from the vendor.
- The University Hospital School staff will conduct monitoring functions for all newborn hearing screening programs. The Iowa Perinatal Review committee has added duties to assist with monitoring of newborn hearing screening systems at hospitals.
- Program software will add newborn hearing fields to the electronic birth certificate and registry. Training will be provided on data entry procedures for these new fields in the electronic birth certificate.

Policy Development

- Convene a newborn hearing work group at least four times a year to discuss systems development for early hearing detection and intervention (EHDI). Title V / IDEA Part C state staff will co-chair this group.
- University Hospital School project coordinator for newborn hearing screening will attend the Area Education Agency (AEA) audiology supervisor quarterly statewide meetings.

Assurance

- As a result of screening newborns, hospital and (AEA) personnel provide service coordination for those newborns who have a hearing screening result indicating a hearing impairment.
- Technical assistance and training will be provided to hospitals via a 28E agreement with University Hospital Schools from IDPH.
- If needed, a statewide conference will be held in winter 2001. The most recent conference was held in March 1999. Other continuing education trainings will be offered to audiologists and hearing screeners statewide.
- Reduce the number of hospitals not screening because of the inability to purchase equipment by offering a grant in the amount of $2000 for the acquisition of the equipment to a minimum of five Iowa hospitals.
- Facilitate dialogue with Title V agencies so they can assist in assuring that infants identified with a hearing loss are followed for continued care/treatment.

11
National Performance Measure

Percent of Children with Special Health Care Needs (CSHCN) in the state CSHCN program with a source of insurance for primary and specialty care.

Type: Capacity
Category: Infrastructure Building Services

4.1 Program Activities Related to Performance Measures

HI2010
11.19 Goal Statement: : Increase to 99% the percent of children in the state (including children with special health care needs) with a source of insurance for primary specialty care.

Relationship to Priority Needs
"Access to care" has consistently over several years been the highest priority need for the Iowa MCH target population as identified by a cross-section of community-based providers from several disciplines. Much of access conceptually relates to financial circumstances, especially having health insurance.

Capacity/Resource Capability
CHSC provides a wide array of direct and enabling services under the support of Title V, but now the emphasis is shifting toward providing core public health functions of assessment, policy development, and assurance. As programs conceptually move away from direct health care services toward infrastructure building services, services will also shift. This will allow greater intensity of effort directed towards informing and outreach services. Much of this effort will involve assuring sources of payment for families needing the more expensive specialty services.

Program Activities

Assessment
- Collect data regarding incidence of payment denial (and reasons for denial) by managed care organizations for CHSC services.

Policy Development
- Plan regional and central CHSC office procedures for detailing the insurance status of families served by CHSC.

Assurance
- Revise program database to capture insurance data on all patients served by CHSC.
- Integrate existing in-house insurance and payment program data into the University of Iowa hospital-based information management system.

12
National Performance Measure

Percent of children without health insurance.

Type: Capacity
Category: Infrastructure Building

4.1 Program Activities Related to Performance Measures

HI2010
11.19 Goal Statement: Increase to 99% the percent of children in the state (including children with special health care needs) with a source of insurance for primary specialty care.

Relationship with Priority Needs
Children without health insurance are identified as target populations for the following identified state priority needs: improve access to primary care for uninsured and underinsured children (SPM #1); increase access to dental health services (SPM #2); reduce disparities among infants (SPM #3); reduce the percentage of high risk infants lost to follow-up (SPM #7); and increase accessibility of mental health services for children with behavioral problems (SPM #9).

Capacity/Resource Capability
The HAWK-I program, Iowa's S-CHIP initiative, has experienced several policy changes during 1999. Effective December 1, 1999, 20% of earned income is disregarded when determining eligibility for the HAWK-I programs. This creates more consistency on how income is counted between Medicaid and HAWK-I. An insert to the HAWK-I brochure was developed to explain the policy. A second policy change relates to depreciation of capital assets, which became effective February 1, 2000. Depreciation of capital assets is allowed as a deduction to income when calculating self-employment income for the HAWK-I program. This change allows children of farmers and self-employed persons, who may not have been previously eligible, to participate in the HAWK-I program.

The Iowa Covering Kids grant from the Robert Wood Johnson Foundation focuses on expanding outreach and enrollment activities to uninsured children and is designed to address the following three goals: 1) design and conduct outreach programs in pilot communities that identify and enroll eligible children into Medicaid and HAWK-I; 2) simplify the Medicaid enrollment process; and 3) coordinate existing coverage programs for low-income children. Year two of the grant begins July 1, 2000. Grant priorities in year two will include 1) developing training manuals on referral options and strategies for Title V providers, and staff of the Healthy Families Line and Teen Line; 2) identify and study the financial impact for twelve-month continuous eligibility for Medicaid and presumptive eligibility for Medicaid and HAWK-I; and 3) continue to convene the task force that focuses on barriers to health insurance access to children and make comprehensive recommendations for removing these barriers.

Program Activities

Assessment
- FSB will identify those groups of children who remain ineligible for insurance.
- The Iowa Healthy Families/Teen Line provides information to families about how to enroll in Medicaid/HAWK-I and how to contact the local EPSDT *Care for Kids* care coordinator to get connected to local services.

- Healthy Child Care Iowa health consultants provide information about options for the uninsured to child care providers through newsletters and/or workshops.
- Title V MCH contractors facilitate the distribution of media materials about enrollment in Medicaid/HAWK-I through Healthy Child Care Iowa health consultants, school-based health services, WIC, schools, HOPES, public health nurses, Head Start centers, and other community partners.
- Title V MCH contractors promote the local dissemination of materials designed by the Iowa Department of Human Services.
- Health Leadership Iowa provides educational opportunities for Title V MCH contractor personnel to develop skills in 1) assessing the numbers of children who are not insured and who are not eligible for Medicaid or the HAWK-I program, and 2) developing a community plan for providing care for those children.

Policy Development

- Community-based MCH contractors inform community partners about eligibility guidelines for the Medicaid/HAWK-I program and enrollment procedures.
- FSB staff advocates for a benefit package for the HAWK-I program that provides comprehensive benefits including preventive services.
- FSB monitors the implementation of the HAWK-I program in Iowa and makes recommendations as appropriate.
- Title V MCH contractors together with community partners develop a community plan for identifying uninsured children and acquainting the family with insurance options.
- Title V MCH contractors convene or actively participate in community planning activities that develop an integrated local system of services for outreach to families with uninsured children.
- Title V MCH contractors participate in community planning activities to reduce barriers to accessing health care services.
- FSB will facilitate the development of health care service models for uninsured children.

Assurance

- Title V Maternal and Child Health contractors assess client insurance status at appropriate intervals and assist families to enroll in appropriate programs as needed.
- Contractors providing women's health services assess the eligibility of the male partners of women of reproductive age for insurance status and refer them for enrollment as appropriate.
- EPSDT care coordinators inform families enrolled in Medicaid *Care for Kids* of insurance programs available and how to move between insurance programs without losing coverage.
- Outreach activities will be provided to families who are eligible for Medicaid/HAWK-I and to community partners who have contact with these families. Outreach activities include 1) identifying children eligible for HAWK-I (up to 185% of FPL); 2) notifying families of the public program, where and how to enroll, and how to maintain enrollment; 3) advising families how to maintain insurance coverage as they move between programs; and 4) educating families about the importance of maintaining regular and periodic well child exams and a medical home.

13
National Performance Measure

Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

Type: Process
Category: Infrastructure Building Services

4.1 Program Activities Related to Performance Measures

HI2010
11.10 Goal Statement: Increase to 95% the percent of Medicaid-eligible children from age 1-21 years of age who have received a service paid for by the Medicaid Program.

Relationship to Priority Needs
This performance measure relates to the MCH priority needs of improving access to primary care for uninsured and underinsured children, increasing access to dental health services, reducing health disparities among infants, and increasing accessibility of mental health services for children with behavior problems.

Capacity/Resource Capability
The passage of the HAWK-I program (SCHIP) in Iowa expands Medicaid eligibility to children with family incomes of 133% of poverty for children ages 1 to 19. Phase II of the Hawk-I program has been implemented and at present is at 13% enrollment. The Iowa Healthy Families Line provides information on enrollment eligibility and refers families to the local community EPSDT care coordinator for assistance in finding a provider. The IDPH has Title V MCH programs with experience in outreach and care coordination in all counties in Iowa. Medicaid administrative claiming, which provides reimbursement for outreach activities, has been expanded in Iowa. There are child care health consultants covering all regions of the state who are providing health information through a network of child care providers. There are newsletters sent to child care providers on a regular basis and workshops where health consultants can reach the providers. A *Care for Kids* Newsletter for EPSDT is sent to health providers around the state. EPSDT Informing and Care Coordination services are available through the child health contractors to children on Medicaid. Medipass and HMO enrollees receive care coordination services through their respective providers and foster children, and medically needy receive care coordination from DHS. Some Title V agencies have contracted to provide care coordination for Medipass and HMO providers, but there is an increase in HMO providers doing their own care coordination services. The EPSDT Interagency Coordinating Committee is monitoring the participation of children enrolled in Medicaid. The capacity of many communities to play a more active role in community development is being increased by Health Leadership Iowa and Empowerment Area legislation. These activities support communities in community development activities to provide the infrastructure for assuring more children eligible for services receive them.

Program Activities

Assessment
- Healthy Child Care Iowa health consultants will provide Medicaid outreach activities to child care providers through established newsletters and/or workshops.
- Title V MCH contractors will facilitate the distribution of media materials about enrollment in Medicaid through their agencies, Healthy Child Care Iowa health consultants, school-based

health services, WIC, schools, HOPES, public health nurses, Head Start centers, and other community partners.
- The EPSDT Interagency Committee will monitor the participation rate of children enrolled in Medicaid, including Medipass and HMOs, and make recommendations.
- Health Leadership Iowa will provide educational opportunities for Title V MCH contractor personnel to improve community assessment and community planning skills.

Policy Development
- Community-based MCH contractors will inform community partners about eligibility guidelines for Medicaid and enrollment procedures.
- Title V Family Services Bureau staff will provide input to DHS in the development of an outreach strategy that includes decreasing the barriers to enrollment in Medicaid.
- Title V MCH contractors will develop a community plan for outreach for increasing enrollment in Medicaid that includes decreasing the barriers for enrollment.
- EPSDT care coordinators will improve community linkages with local Medicaid providers for referral and follow-up of Medicaid children.

Assurance
- Title V maternal and child health contract agencies will assess client eligibility for Medicaid at appropriate intervals and assist families to enroll as needed.
- EPSDT care coordinators will inform families enrolled in Medicaid *Care for Kids* of available services, reinforce the importance of regular well child medical and dental visits, and assist them to overcome the barriers to receiving services.
- Medicaid Administrative Claiming contractors will educate families about eligibility for Medicaid and the need to enroll in a timely manner to maintain services.
- The Healthy Families/Teen Line will provide information to families about how to enroll in Medicaid and how to contact a local Medicaid care coordinator to get connected to local services.
- Outreach activities will be increased to families and community partners who have contact with families who are eligible for Medicaid. Outreach activities include 1) identifying other eligible children of families enrolled in Medicaid; 2) notifying families of eligibility guidelines for Medicaid, where and how to enroll, and how to maintain enrollment; 3) advising families how to maintain insurance coverage as they move to other programs such as HAWK-I; and 4) educating families about the importance of establishing well child and dental medical homes.

14
National Performance Measure

The degree to which the state assures family participation in program and policy activities in the state CSHCN program.

Type: Process
Category: Infrastructure Building Services

4.1 Program Activities Related to Performance Measures

HI2010
11.18 Goal Statement: Insure that Iowa is one of the states and territories that has a service system for children with or at-risk for chronic or disabling conditions, as required by Public Law 101-239.

Relationship to Priority Needs
Under OBRA '89 legislation, Title V programs are charged with providing and promoting family-centered, community-based, coordinated care (including care coordination services) for CSHCN and to facilitate the development of community-based systems of services for such children and their families.

Capacity/Resource Capability
CHSC has supported a Parent Partnership Program for nearly a decade. A full-time parent coordinator housed in the central administrative office staffs the program. The 13 CHSC regional child health centers have access to trained community-based parent consultants who provide parent-to-parent support, problem solving assistance, and information and referral services. The parent consultants are all parents of their own CSHCN and are compensated for their consultation efforts with remuneration and expense reimbursement.

Program Activities
Assessment
- Review current CHSC program priorities with regard to the performance measure's list of selected family participation characteristics.
- Continue to survey the CSHC parent coordinator and parent consultants for family participation improvement strategies.
- Assess involvement of other parents and parent groups who voluntarily participate in various program and policy activities.

Policy Development
- Based on review of current family involvement in the state CSHCN program, develop program policies to increase participation in programmatic areas deficient in family participation.

Assurance
- Based on parent-consultant survey results, provide continuing education opportunities to parents and parent groups regarding continuing and changing functions of the Iowa Title V Program for CSHCN.

15
National Performance Measure

Percent of very low birth weight live births.

Type: Risk Factor
Category: Infrastructure Building Services

4.1 Program Activities Related to Performance Measures

HI2010
11.2 Goal Statement: Reduce the overall low birth weight to an incidence of no more than 5% of live birth and overall very low birth weight to no more than 1% of live births.

Relationship to Priority Needs
Iowa's incidence of very low birth weight births (VLBW) per 100 live births for all residents has increased from 0.92% in 1993 to 1.1% in 1999. The rate of VLBW Black infants has decreased, from 2.4% in 1993 to 2.3% in 1999, indicating that while the rate of very low birth weight births to black has decreased, there remains a disparity between the overall rate and that of VLBW Black infants.

Capacity/Resource Capability
Initiation of prenatal care during the first trimester is a key factor in influencing birth outcome, i.e. carrying to or closer to term, and the decreased incidence of very low birth weight infants. The Iowa Department of Public Health continues to provide leadership for activities that influence delivery of prenatal services. Activities include programs provided by local contract agencies to provide prenatal care and care coordination of health care for women during pregnancy; surveillance such as the *Barriers to Prenatal Care* survey and the maternal database (scheduled to be implemeted FFY2001) to determine deficiencies in the system; participation in councils and other bureaus to decrease substance abuse during pregnancy; etc. Local maternal health agencies conduct Medicaid eligibility determinations and facilitate early entry into care and provide the Medicaid enhanced services to high-risk clients.

Program Activities

Assessment
- Continue *Barriers to Prenatal Care* survey, as well as the new maternal health database, monitoring of unintended pregnancies
- Monitor interpregnancy intervals, and educate communities as to the health benefits of pregnancy spacing of at least 16 months. Encourage referrals to local family planning services.
- Evaluate data to assess the disparities in the number of Black very low birth weight babies compared to the total population. Ensure state capacity for assessment, epidemiology, evaluation, and cost analysis.
- Review outcomes of enhanced prenatal care. Promote the use of the enhanced services package to private providers.

Policy Development
- Continue collaboration with the IDPH Bureau of Health Promotion, Tobacco Cessation program to provide staff development in counseling techniques of smoking cessation. Individual agencies will continue to emphasize the importance of smoking cessation for pregnant clients.
- Advocate for improved utilization of Medicaid enhanced services to high risk pregnant women.

- Advocate for family support programs and service coordination.
- Participate and provide staff support to the Council on Chemically Exposed Infants and Children.
- Support the Iowa Repetitive Preterm Birth Prevention program to prevent low birth weight and very low birth weight infants.
- Advocate for improved access to early prenatal are for undocumented (immigrant) women.

Assurance

- Continue to assure access to prenatal care through private and public providers. Maternal health contract agencies will provide comprehensive, community based, culturally competent, family centered care. Continue to integrate maternal health services with WIC, family planning services, and DHS programs.
- Continue enabling services to include referrals to the WIC program or registered dietitians, assistance in obtaining Medicaid or other subsidized medical care, and assurance of access to comprehensive genetic services.
- Reduce violence, alcohol use, tobacco use, and other substance abuse in the maternal health population.
- Continue distribution of *Early Prenatal Care* brochure and Health Diaries available in English and Spanish. Distribution will continue to contract agencies and others serving low income clients such as School Based Youth Services Programs (SBYSP).
- Enable local MCH programs to translate client education materials into useable form for their specific client population.

16
National Performance Measure

The rate (per 100,000) of suicide deaths among youths aged 15-19.

Type: Risk Factor
Category: Infrastructure Building Services

4.1 Program Activities Related to Performance Measures

HI2010
12.5 Goal Statement: Make service available to all children, youth and their families within the immediate context of family and community.

Relationship to Priority Needs
This performance relates closely to the state performance measure of increasing accessibility of mental health services for children with behavior problems. Suicide was the second most frequent cause of death among Iowa's 15-24 year olds in 1998. Twenty-two suicides out of 134 total deaths comprised 16.4% of the deaths among the 15-19 year olds. (1998 Iowa Vital Statistics). Incidence is greatest among white males.

Capacity/Resource Capability
Although this objective targets areas identified by MCHB, specific programs directed at impacting suicide rates are not within IDPH programming areas assigned to FSB. The FSB continues to advocate for appropriate programming related to mental health issues. Local Title V programs and interagency initiatives incorporate program components that support mental health screenings and client access to mental health providers.

Program Activities

Assessment
- Emphasize the psycho-social assessment used for screening Title V and EPSDT clients.
- Provide information to the Teen Line and Healthy Families Line as a source of referral for mental health services for youth and families.

Policy Development
- Through Iowa's designated Title V agencies, increase awareness among health care providers and other community service providers of the importance of care coordination including referral and treatment for mental health services.
- Promote increased awareness and utilization of the Teen Line.
- Promote the development of the mental health component of the School Based Youth Services Program administered by the Department of Education and supported by a multi-agency team including FSB staff.

Assurance
- Improve staff evaluation skills regarding emotional functioning.
- Increase staff awareness of factors that may delay access to mental health services.

17
National Performance Measure

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Type: Risk Factor
Category: Infrastructure Building Services

4.1 Program Activities Related to Performance Measures

HI2010
11.3 Goal Statement: Increase to at least 95% the proportion of very low birth weight infants born at facilities for high-risk deliveries and neonates.

Relationship to Priority Needs
No state priority need directly relates to this national performance measure.

Capacity/Resource Capability
The Title V program participates in and supports two programs: Iowa Repetitive Premature Birth Prevention Services and the Iowa Regionalized System of Perinatal Health Care. The Iowa Repetitive Premature Birth Prevention Services (IRPBPS) was established to prevent a portion of subsequent premature births to women who have sustained late spontaneous abortions or early preterm deliveries by identifying potentially correctable factors through a comprehensive evaluation. In 1997, IDPH published the 7th edition of the Guidelines for Perinatal Centers. This document is widely recognized in the state as a best practice model for organizing service delivery in a rural state.

Program Activities

Assessment
- Convene the statewide Perinatal Guidelines Advisory Committee to review the Iowa Regionalized System of Perinatal Health Care based on recommendations of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Policy Development
- Continue to support the Iowa Repetitive Premature Birth Prevention Program to help prevent future low birth weight infants.

Assurance
- Continue support of the Statewide Perinatal Health Care Program to provide on-site education and review visits to hospitals that deliver babies in Iowa.
- Level II, Level II Regional, and Level III hospitals are visited at least annually, all other obstetrical facilities are visited on an established schedule. More frequent visits may be made on the basis of local requests and needs.
- The tertiary hospitals provide outreach education for healthcare staff in outlying hospitals. Additionally, they provide maternal and neonatal transport services.

18
National Performance Measure

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Type: Risk Factor
Category: Infrastructure Building Services

4.1 Program Activities Related to Performance Measures

HI2010
11.16 Goal Statement: Increase to at least 90% the proportion of all pregnant women who begin prenatal care in the first trimester of pregnancy.

Relationship to Priority Needs
Women receiving adequate prenatal care tend to be healthier and give birth to healthier, normal-weight babies.

Capacity/Resource Capability
Direct care and enabling services program activities were provided by 26 contract community-based agencies serving all 99 Iowa counties. Agencies provide services to facilitate early entry into prenatal care including Medicaid presumptive eligibility determination, tracking for follow-up, and outreach. Outreach efforts included strategies for communicating with hard to reach populations, plans for informing community residents of available services, strategies for coordinating with community organizations and health and human services providers. Agencies also identified strategies for coordinating with civic groups and other similar organizations, and assisting clients in obtaining a medical home for consistent prenatal care. Special emphasis was placed on building linkages with Title X Family Planning services.

Program Activities

Assessment
- Assess birth certificate and Maternal Health Database information to determine the population in need of specific efforts.
- Provide technical assistance to maternal health agencies on strategies to access and serve hard to reach populations.

Policy Development
- Continue Title V funding for geographically accessible maternal health centers.
- All 26 maternal health centers are able to provide presumptive eligibility to pregnant women.
- Promote communication and collaboration between maternal health centers, other local agencies, and local providers for maternal referral.
- Collaborate with the Department of Human Rights on serving hard to reach populations.
- Review collaboratively with DHS the prenatal presumptive eligibility program and revise as necessary.
- Seek representation from at risk populations to serve in an advisory capacity for policy development.
- Advocate for improved access to early prenatal care for undocumented (immigrant) women.

Assurance

- Continue to assure access to prenatal care through public and private providers. Maternal health contract agencies will provide comprehensive, community-based, culturally competent, family centered care. Continue to integrate maternal health services with WIC, family planning services, and DHS programs.
- Continue distribution of *Early Prenatal Care* brochure and Health Diaries available in English and Spanish. Distribution will continue to contract agencies and others serving low-income clients such as School Based Youth Services Programs (SBYSP).
- Continue support for the Healthy Families and Teen Line.
- Enable local MCH programs to translate client education materials into useable form for their specific client population.

03
State Performance Measure

Percent of children served by Title V, excluding CSHCN, who report a medical home.

Type: Capacity
Category: Enabling Services

4.1 Program Activities Related to Performance Measures

HI2010
11.9 Goal Statement: Increase to 91% the percentage of children in Iowa, including those with special health care needs who have a medical home and/or health home as defined by the American Academy of Pediatrics.

Relationship to Priority Needs
Title V has the opportunity to secure a medical home for every child served in a child health program. Title V also provides outreach to families and children not currently participating in child health programs, thereby assisting additional uninsured and underinsured children to access primary care and establish a medical home Establishment of a medical home promotes assurance of continuity of health care and related services.

Capacity/Resource Capability
The child health agencies provide care coordination for Title XIX clients, Title XIX clients not covered by HMO's, and the Title XIX clients in child health programs with established agreements with HMO's for care coordination. An increase in the number of primary care providers combined with community collaborations will result in increased capacity of health delivery systems to provide services. With Medicaid expansion (effective July 1, 1998) and expansion of HAWK-I to 200% FPL (effective July 1, 2000), more families have the opportunity to establish a medical home for their children.

Program Activities

Assessment
- Develop a sample survey methodology and tool.
- Implement telephone survey.
- Analyze results of survey.
- Report medical home data to local, state, federal, and other constituency groups.

Policy Development
- Use Robert Wood Johnson outreach strategies for Title XXI to increase access to stable source for medical care and establish medical home for children.
- Advocate for establishment of annual Medicaid eligibility for children.
- Advocate for Medicaid presumptive eligibility for children.
- Continue participation on the Iowa Comprehensive Child Health Care System Quality Assurance Team.

Assurance
- Increase to 15 the number of targeted child health contractors who establish community-based outreach activities with Child Care Resource and Referral agencies and Head Start Programs.
- Provide informing and care coordination services to all Title V child health clients regarding local medical providers.

- Provide child health clinical services for children as needed until a medical home is secured.

04

State Performance Measure Percent of low income children (ages 1-4) enrolled in child health centers who have completed a referral to a dentist.

Type: Process
Category: Enabling Services

4.1 Program Activities Related to Performance Measures

HI2010
15.8 Goal Statement: Increase to at least 70% by the year 2010, the proportion of school-aged children who have received a dental exam, referral and treatment of all identified oral health problems centers who have completed a referral to a dentist.

Relationship to Priority Needs
Dental sealants for children have been identified as a priority for children prior to third grade level. Iowa identified that basic access to dental health continues to be a major issue throughout the state. The following activities identify strategies to obtain the national level measure.

Capacity/Resource Capability
The Dental Health Bureau is comprised of an Interim Dental Health Bureau Chief and two dental hygienists who provide technical assistance, monitoring, training and consultation to all 36 MCH centers that provide community based dental health programs statewide.

Program Activities

Assessment
- The Dental Health Bureau will continue to encourage infrastructure-building through child health centers to establish dental homes for low-income children.

Policy Development
- The Dental Health Bureau continues to participate in committees that address the dental access problem. These include: Special Committee on Dental Access, QA EPSDT Subcommittee, EPSDT Interagency, Medicaid Policy Committee, Division Child Health Team and EPSDT Team, and the Iowa Oral Health Action Committee. These committees ensure that oral health is an integral part of total health and initiatives are set to improve access for low-income families.
- The Dental Health Bureau with the support of Family Service Bureau will fund four Iowa Access to Baby Child Dentistry (ABCD) Programs. These programs are modeled after the Spokane Washington program. Children birth to age five whole income is at or below the level established for the state's Title XXI program (Hawk-I and /or children enrolled in EPSDT/Care for Kids are a priority. The Iowa ABCD program relies on prevention services, care coordination and a child/parent education model as the foundation to improve access to service and to promote life long practices of oral health.

Assurance
- The Dental Health Bureau continues to work with local child health agencies on care coordination activities and infrastructure-building activities to establish assure dental services for low-income families. These care coordination activities include assurance that

transportation needs are met for the client to the dental appointment, affirming and re-affirming the dental appointment with the patient, coordination with the dental office to assess any problems or follow-up with the dental visit and client education of how to be a "good'/responsible dental patient to assure that no-shows are minimized.

- The Dental Health Bureau now makes the school dental card free upon request to encourage regular dental visits for all children entering school.

08
State Performance Measure

Degree to which key data are collected, managed, analyzed, and utilized for strategic assessment of the determinants and consequences of the health status of women and families.

Type: Capacity
Category: Infrastructure Building Services

4.1 Program Activities Related to Performance Measures

HI2010
11.20 Goal Statement: Increase to a score of 45 out of 60, the degree to which Iowa develops a data system for assessment of the health of women, children, and families.

Relationship to Priority Needs
This state performance measure is indirectly related to improving the quality of services to women, children and families. The quality of analysis and provision of data are major component of the related priority need. Quality is enhanced through the development of a data tracking system and staff development.

Capacity/Resource Capability
Data utilization and linkages technical assistance received in September 1997 (by Greg Alexander, RS, MPH, ScD) provides a foundation for plan development. The recommendations from the site visit and the data inventory serve as a basis for planning. Program personnel are actively involved in information/data based decision making and program planning. The Health Leadership Iowa (CISS-COG) initiative provides resources and supports new collaborative efforts to improved data capacity as illustrated by partnership with ISU Extension and Data Use Academy (U of N). (Title V funds support a community Health consultant assigned to DPH's Center for Health Statistics). Resources have been identified for development of linked electronic data systems for maternal health and child health services.
CHSC has supported a parent partnership program for over a decade. The 13 CHSC regional centers have access to trained community-based parent consultants who provide parent-to-parent support, problem solving assistance, and information and referral services. The parent consultants are all parents of their own CSHCN and are compensated for their consultation efforts with remuneration and expense reimbursement. The restructuring of CHSC family participation will build on this historic capacity.

Program Activities

Assessment
- Maintain an ongoing division level data work group and report to bureau staff. Identify performance and monitoring indicators and discuss the accessibility, diagnosis and investigation of population-wide health data that address health problems affecting women, children and families.
- Facilitate a work group to engender involvement from contract agencies to improve the capacity, integration, and quality of the software and hardware for data regarding problems affecting women, children, and families. Submit regular reports to the FSB Grantee Committee.
- Explore resources for obtaining accurate data sources and investigate methods to manipulate and analyze data.

- Facilitate periodic communications to explore data sources with working groups to identify sources of data that are not presently available and improve the timeliness of data that is accessible.
- Enhance data skills and capacity of selected staff and grantee representatives by conducting a Data Use Academy (supported in part by HLI).
- Expand communication with Vital Records Bureau to increase the effective use and accessibility of vital statistics data to boost inter-program relationships and improve productivity.
- Facilitate efforts to link vital records and Family Services data with other programs, such as WIC, Medicaid, and managed care for the purposes of needs assessment and surveillance.
- Review current CHSC program initiatives to determine whether improvement is seen with regard to the performance measure's list of selected family participation characteristics.
- Determine relationships between employed parents and other parents and parent groups who voluntarily participate in various programs and policy activities.

Policy Development

- Coordinate efforts with departments of Center for Health Statistics and Information Technology to make data sets available electronically.
- Provide technical assistance to Family Services program staff and contract agency staff by assigned persons or consulting services. Address data collection, analysis, presentation and publication of data about health problems affecting women, children and families.
- Develop a strategic plan to guide progress toward improving the data-use capacity of Title V programs
- Develop a standardized data storage, sharing and documentation system for Family Services staff.
- Develop strategies for display and dissemination to stakeholders and MCH/family advocates.
- Based on review of current family involvement in CHSC, develop program policies to increase participation in programmatic areas deficient in family participation.
- Define the position of parent consultant, including skill requirements, job responsibilities, an supervisory relationships.
- Create a flexible work environment that is sensitive to the needs of families and built around the families' needs and capacities.
- Collaborate with Family Voices, Iowa's Parent Training Initiative, and Iowa's Parent Educator Connection to enhance the capacity of the CHSC Parent Network.

Assurance

- Improve access to accurate data sources through further development of Infrastructure Building activities.
- Submit an application for SSDI for conducting a statewide household survey for child and family health.
- Participate in MCHB and CDC sponsored data enhancement opportunities.
- Evaluate new structure of CHSC parent participation to determine involvement of all families and at all organizational levels.
- Assess the achievement of parallel partnerships between families and professionals.
- Assess the achievement of a shared vision between families and professionals.

09

State Performance Measure Degree to which Iowa's providers of general medical care services to CSHCN use quality improvement strategies in their practices

Type: Process
Category: Infrastructure Building Services

Program Activities Related to Performance Measures

HI2010
11.18 Goal Statement: Insure that Iowa is one of the states and territories that has a service system for children with or at-risk for chronic or disabling conditions, as required by Public Law 101-239.

Relationship to Priority Needs
As a public health program, CHSC assumes responsibility for addressing the core public health functions of assessment, policy development, and assurance. As a provider of specialty services, CHSC must be concerned with not only the quality of its own services, but also the quality of the primary and preventive services that form a foundation of good health care for any child. It is, therefore, reasonable for CHSC to involve itself in monitoring and improving quality of care.

Capacity/Resource Capability
CHSC's regional network of child health centers provides a community-based resource to CSHCN and their families. Collaborative relationships with other health, education, and human service providers form a basis for service system development. Most referrals to CHSC regional centers are from primary care providers who in turn receive assistance and recommendations for further health care and care coordination. Selected central office and regional office staff are expected to develop skills in quality improvement for purposes of optimizing the effectiveness of the community-based health service system.

Program Activities
Assessment

- Summarize and distribute the data collected in the initial survey to the pediatricians and family practice physicians who participated in the survey.
- Appropriately revise the survey instrument before redistributing it in the Fall of 2000.
- Redistribute the survey instrument and compare the new data to the baseline data obtained in FY 99/00.
- Investigate the quality improvement measures required of physicians by Medicaid.

Policy Development

- Develop definitions to accompany the general quality improvement activities included on the survey.
- Consult with the Iowa Chapters of the American Academy of Pediatrics and the American Academy of Family Physicians regarding their expectations and policies for quality improvement training and activities.

Assurance

- Share the survey results and other CHSC experiences and data with the above-mentioned professional academies and Iowa's Early ACCESS technical assistance team and jointly plan quality improvement strategies.

CHECKLIST FOR QUALITY IMPROVEMENT MEASURES IN A GENERAL PEDIATRIC PRACTICE

Score is for Federal Fiscal Year: 1999

0 = no use of measures for this area
1 = irregular use of measures for this area
2 = consistent use of measures for this area

- Administrative Measures 0 [1] 2
- Family Surveys 0 [1] 2
- Provider Surveys 0 [1] 2
- Clinical Effectiveness 0 [1] 2
- Accessibility of Care 0 [1] 2
- Collaborative Relationships [0] 1 2

Total Score: 05

11
State Performance Measure

Percent of counties that report screenings and referrals for behavioral problems in young children (ages 3-5).

Type: Capacity
Category: Direct Health Care

Program Activities Related to Performance Measures

HI2010
12.5 Goal Statement: Make services available to all children, youth, and their families within the immediate context of family and community within rural and urban areas of the state by 2005; and respond to the unique and changing needs of all consumers in a culturally appropriate manner.

Relationship to Priority Needs
Behavioral and emotional problems in children have gained increasing attention and priority in the national and state public health systems over the last two decades. Using state and local collaborative relationships, Iowa's Title V program has the opportunity to foster the development of an integrated and comprehensive system of child mental health services. Fundamental and necessary to a comprehensive mental health service system are screening and referral activities.

Capacity/Resource Capability
Greater recognition of the influence of family dynamics on the overall health of children is prompting development and use of family assessment instruments to direct intervention strategies. Family stress, family connection, substance use, parenting practices, and child and adolescent behavior are all issues in which the Iowa Title V MCH and CSHCN programs have interest. A "Family Quality of Life" paradigm has been developed and introduced as a concept to unify physiological, psychosocial, and environmental public health concerns. Concern and support for mental health initiatives is also growing in other public and private arenas.

Program Activities

Assessment
- Need to document child and maternal health service providers in counties.
- Use public health nurses' and County Boards of Health's data to analyze and document referral practices for children's mental health and behavioral problems.
- Create a work group to identify barriers to identifying and referring children with behavioral problems.
- Recommend and make available screening instruments or methods.

Policy Development
- Design and implement policies for MCH agencies to document and report screens and referrals of children for behavioral problems.
- Help train child care providers in informal screenings and referrals.
- Secure additional funds to support a mental health coalition targeting mental health promotion and prevention activities in child care environments.
- Collaborate with Iowa Health System to develop 12 child care material kits for use by child care providers and families regarding prevention of mental health morbidity in children.

Assurance

- Give Title V agencies the responsibility to be a resource to other community agencies and providers regarding the identification and treatment of behavioral and mental health problems in children.
- Provide training in the use of instruments to assess children with behavioral problems.
- Provide the means to allow Title V agencies to offer communities technical assistance and education regarding screenings and referring children with behavioral problems.
- In collaboration with other departments and agencies develop plans and strategies to assure access to mental health services through public and private providers.
- Provide educational materials to MCH agencies, private providers, educators, and parents regarding issues of children's mental/behavioral health status and health service utilization.

12

State Performance Measure — Percent of CSHCN enrolled in Title XIX Medicaid Managed Care or Title XXI HAWK-I that have their needs identified and met.

Type: Capacity
Category: Enabling Services

Program Activities Related to Performance Measures

HI2010
11.9 Goal Statement: Increase to 91% the percent of all children in Iowa, including those with special health care needs, who have a "medical and/or health home" as defined by the American Academy of Pediatrics.

Relationship to Priority Needs
As the predominance of managed care has grown, there has been a corresponding increase in concerns for quality of care, especially for CSHCN. Strategies to assure quality include focused attention on providing and coordinating services, including specialty care services.

Capacity/Resource Capability
CHSC has extensive experience in providing direct health care and care coordination services to a diverse group of CSHCN. A regional network of child health centers provides a community-based resource to CSHCN and their families. CHSC staff at the central office and at the community level have been involved with advising the Department of Human Services (DHS) and the HAWK-I board regarding the identification of and service requirements for CSHCN.

Program Activities

Assessment

- Develop a methodology to actualize a statewide definition of "children with special health care needs" and implement data collection to identify CSHCN in Medicaid Managed Care and HAWK-I.
- Develop criteria to assess the quality of services provided to CSHCN enrolled in Medicaid Managed Care and HAWK-I.

Policy Development

- Establish an acceptable statewide definition of "children with special health care needs."
- Obtain multi-agency support to implement data collection initiatives related to service quality within the insurance programs identified for CSHCN.

Assurance

- Analyze data to determine performance of providers and payers in delivery of services to CSHCN.
- Provide technical assistance to DHS and other Managed Care Organizations to develop strategies to address any identified service deficiencies.

13
State Performance Measure

Percent of infants determined to be at-risk receiving monitoring and follow-up services at age 12 months.

Type: Process
Category: Population Based Services

4.1 Program Activities Related to Performance Measures

HI2010
11.8 Goal Statement: Increase to 80% the percentage of infants identified in the state as high risk who receive follow up or appropriate discharge through 30 months of age.

Relationship to Priority Needs
Through access to care coordination, children will receive adequate health care and follow-up designed around their health care needs. This will increase access to dental services, reduce health disparities among pregnant women and infants, improve family support services by linking families to those services and increases accessibility of mental health services for children with behavior problems. Community care coordinators collaborate with local community partners to develop linkages for referrals to children with obesity.

Capacity/Resource Capability
Through collaboration with DHS, Iowa has care coordination and informing contractors in every county in Iowa. Every contractor has a computer software program supplied by the state to support the coordination activities for tracking and billing. MCH/FSB staff provides technical assistance and workshops to contractors for care coordination activities and computer support. MCH/FSB staff collaborates with intra-agency partners to monitor and evaluate care coordination services.

Program Activities

Assessment
- Provide technical assistance and support for a software computer tracking system.
- Provide a monthly list of all new Medicaid eligible clients to all Title V contract agencies.
- Continue to provide technical assistance to child health contract agencies to develop accurate costs for informing and care coordination services.
- Continue with development of new data collection methods at the state and county levels to give a more accurate picture of EPSDT utilization.
- Collaborate with DHS to obtain managed care encounter data.
- Continue to collaborate with Environmental Health Bureau to develop a baseline of children screened for lead by county by matching Lead data to the Medicaid data.
- Review EPSDT participation rate data for patterns and trends.

Policy Development
- Encourage and provide technical assistance for local communities to develop community linkages.
- Provide technical assistance / training regarding access to services for culturally/racial diversified populations.

- Continue collaboration with Head Start and expand Healthy Child Care Iowa sites.
- Facilitate coordination between Title V child health contractors and school based youth services.
- Expand mechanisms for increasing outreach to potentially eligible Medicaid children to increase number of children enrolled.
- Continue to facilitate the EPSDT *Care for Kids* interagency coordinating committee to facilitate increased utilization.
- Increase access to oral health services through expansion of the OBRA mandate.

Assurance

- Provide technical assistance to contract agencies to improve their system of care coordination for children and their families.
- Continue publication of the EPSDT *Care for Kids* newsletter.
- Continue to use the 1-800 Healthy Families telephone line to inform and refer families to local EPSDT services.
- Provide technical assistance to agencies and schools participating in Medicaid Administrative Claiming.

14
State Performance Measure

Ratio of black-to-white preterm births.

Type: Risk Factor
Category: Population Based Services

4.1 Program Activities Related to Performance Measures

HI2010
16.14 Goal Statement: Reduce the overall perinatal mortality rate to no more than 7.1 per 1,000 (the calendar year 2001 target is 10.1 per 1,000) live births plus fetal deaths (for example, deaths from 20 weeks gestation to 7 days after birth). (Baseline: calendar year 1998 overall perinatal mortality rate was 9.5 per 1,000, the white rate was 9.1 per 1.000, the black rate was 17.6 per 1,000, and the Hispanic rate was 13.9 per 1,000.)

Relationship to Priority Needs
Although the overall infant mortality rate for Iowa has approximated the Federal 2000 goal of 7 deaths per 1000 live births, there continues to be a wide disparity in the rates for black and white infants. Infant mortality rates (IMR's) vary substantially among and within all racial and ethnic groups. National data show that infant death rates among blacks, Native American, and Alaska Natives, and Hispanics in 1995 or 1996 were all above the national average of 7.2 deaths per 1,000 live births. The greatest disparity exists for blacks, whose infant death rate (14.2 per 1,000 in 1996) is over 2 times that of white infants (6.0 per 1,000 in 1996). The overall Native American rate (9.0 per 1,000 live births in 1995) does not reflect the diversity among Indian communities, some of which have infant mortality rates approaching twice the national rate. Similarly, the overall Hispanic rate (7.6 per 1,000 live births in 1995) does not reflect the diversity within this group, which had a rate of 8.9 per 1,000 live births among Puerto Ricans in 1995. In Iowa, the black infant mortality rate is more than three times the white rate. In calendar year 1998, the overall infant mortality rate was 6.0 per 1000, while the black infant mortality rate was 18.5 per 1000, compared with a white infant mortality rate of 5.6 per 1000. Among the leading cause of deaths in infants, the racial and ethnic disparity is greatest in disorders related to preterm birth; including respiratory disease, infections, and nutritional deficits.

Need Statement:
Reduce the ratio of black-to-white preterm births to no more than 1.0(indicating no disparity).

Capacity/Resource Capability
Family Services Bureau staff and the 26 maternal health contract agencies have many years experience in providing prenatal services for pregnant women, including outreach to minorities and hard-to-reach populations, care coordination, referrals, and targeted case management. Contractors are encouraged to target minority populations in their annual action plans. There are two Healthy Start Programs in the state, that provide prenatal services for minority and low-income populations in areas of high infant mortality.
The effectiveness of these services will be assessed annually, with the capacity to evaluate the contractor activities monthly through the maternal health database.

Program Activities

Assessment

- Utilize the maternal health database to monitor minority outreach activities of the contractors; the provision of prenatal services, including enhanced services for pregnant women; and the effectiveness of prenatal outreach and education programs.
- Monitor factors proven to put women at risk for preterm delivery, such as substance abuse, smoking, high blood pressure, infection.
- Review outcomes of enhanced services for pregnant women. Promote the use of enhanced services package to private providers.

Policy Development

- Continue collaboration with Department of Human Services to monitor and promote enhanced services for pregnant women.
- Advocate for family support programs.
- Encourage targeted outreach to minority populations.
- Continue support of the Iowa Repetitive Preterm Birth Prevention program to prevent preterm births in at-risk women.

Assurance

- Continue to assure access to prenatal care through public and private providers.
- Provide outreach and information to minority populations to encourage early, regular prenatal care through a medical home.
- Reduce violence, alcohol use, tobacco use, and other substance abuse in the maternal health populations.
- Continue to provide educational materials to public health programs and pregnant women.
- Promote and maintain standards of care as defined by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

15
State Performance Measure

Percent of WIC clients ages 2-5 that are overweight at or above the 95th percentile as defined by the PedNSS.

Type: Risk Factor
Category: Popuation Based Services

4.1 Program Activities Related to Performance Measures

HI2010
13.4 Goal Statement: Decrease the rate of weight gain that is occurring among children and adolescents in Iowa (< 18 years). The increasing prevalence of overweight children and adolescents will be halted to prevent a further rise in prevalence rate from the level estimated to be 8.1 percent.

Relationship to Priority Needs
By learning healthy dietary patterns and physical activity, children can develop lifelong patterns that will reduce the likelihood of obesity in later life.

Capacity/Resource Capability
The Iowa Department of Public Health funds WIC programs, providing nutrition education in all counties, and has the infrastructure to ensure provision of child health services in all counties. Through the Iowa Department of Education, contact can be made with school nurses, school athletic directors, physical education instructors, and counselors as well as classroom teachers. Nutrition education is promoted through the school lunch programs. The Iowa Nutrition Education Network seeks grant funds to promote nutrition education and physical fitness activities in Iowa through social marketing campaigns and mini-grants to local communities. The Child and Adolescent Obesity Task Force was formed to address the specific problem of child obesity and includes representatives from education, Head Start, Child Care Resource & Referral, WIC, mental health, Iowa State Extension, Iowa Association of Physical Health Education, Recreation and Dance and a variety of other organizations.

Program Activities

Assessment
- Develop a list of resources to share with professionals that can be used in obesity prevention efforts. (Child and Adolescent Obesity Task Force)
- Develop a speaker's bureau to speak to professionals, parents and interested groups. (Child and Adolescent Obesity Task Force)
- Continue to track pediatric nutrition surveillance data on overweight for children on WIC. (Bureau of Nutrition and WIC)
- Continue to track Youth Risk Behavior Survey (YRBS) data on youth that report they are overweight: physical activity, fat intake and fruit and vegetable intake. (Family Services Bureau and Bureau of Nutrition and WIC)

- Begin to track new data on self reported Body Mass Index (BMI) in the YRBS. (Family Services Bureau and Bureau of Nutrition and WIC)
- Pilot a program to report measurements of heights and weights from schools through the Pediatric Nutrition Surveillance System.

Policy Development

- Complete the issue briefs and obtain consensus from agencies represented on task force for the recommendations in the paper. (Child and Adolescent Obesity Task Force)
- Convene a meeting to plan future activities and outreach. (Child and Adolescent Obesity Task Force)
- Assist the University of Iowa in developing protocols for treatment of childhood obesity and promoting distribution of the information to health care practitioners. (Child and Adolescent Obesity Task Force)
- Support INEN in implementing the statewide marketing campaign on increasing fruit and vegetable consumption and physical activity. (Bureau of Nutrition and WIC)
- Continue to support INEN and the Department of Education in expanding Team Nutrition and quality physical activity experience in schools. (Bureau of Nutrition and WIC)
- Continue to meet with interdepartmental groups such as the Health Promoting Schools Committee and the Iowa Coalition for Comprehensive School Health to promote obesity prevention activities. (Family Services Bureau and Bureau of Nutrition and WIC)

Assurance

- Encourage early childhood educators and programs that offer parenting classes to promote healthy nurturing practices in the feeding relationship. (Child and Adolescent Obesity Task Force)
- Develop an exhibit on child obesity prevention, featuring physical fitness promotion and health eating to present at professional meetings.
- Distribute position papers to individuals and organizations statewide that work with children ages 0-21.
- Hold a statewide conference on child obesity for WIC, Head Start, and Child Care providers.
- Conduct focus groups with parents of overweight children in WIC to determine how physical fitness and nutrition messages in WIC clinics are perceived.
- Assist local WIC agency staff to hold demonstrations on ways parents and children can participate in physical activity.
- Send WIC staff to Pace Physical Training.
- Promote schools use of existing guidelines from IAPHERD (Iowa Association of Physical Health Education and Recreation Dance) for model physical education programs and proposed guidelines from the Iowa Department of Education.

16
State Performance Measure

The percent of families of 1 year old children enrolled in WIC who have participated in parenting education.

Type: Process
Category: Infrastructure Building Services

4.1 Program Activities Related to Performance Measures

HI2010
11.7.3 Action Step Statement (under the goal statement to reduce child mortality): Expand the "Health Opportunities for Parents to Experience Success Programs" to deal with issues related to parenting skills deficits.

Relationship to Priority Needs
This state performance measure is related to improving positive and appropriate parenting skills.

Capacity/Resource Capability
WIC clinics conduct parent education classes for their clients. MCH agencies will also be providing resources for parents on parenting education classes offered throughout their community.

Program Activities

Assessment
- Utilize WIC data to record and report on parents who are participating in parenting education.
- Conduct a survey of WIC clients who have participated in parent education classes in the past year or would like to attend class.
- Develop a database of the all the parent education classes offered throughout the state.
- Track parent education request received through Iowa Healthy Families Line toll free phone line.
- Coordinate activities with RWJ funded Iowa Review of Family Assets project.

Policy Development
- Assemble a workgroup to identify barriers within state policy and procedures that my act to impede the development of strong emotional and financial bonds of support between both parents and their children.
- Collaborate with the Department of Education on approaches to surveying, evaluating, and recommending parenting education classes.
- A statewide conference will be offered on the approaches to parent education and principles of raising children.
- Coordinate activities with the state's newly developing "Fatherhood Initiative".
- Develop strategies with MCH/WIC providers that reinforce utilization of parent education programs.

Assurance

- Access the availability and quality of classes in the counties and work with the communities to fill gaps in these programs and improve their quality.
- Support Title V agencies involvement in parent education enhancement training provided through Early Access.
- Enhance referral services for parent education resources through Healthy Families toll free line.

4.2 Other Program Activities

The program has been extensively involved in providing leadership for changes in the service delivery system for children including but not limited to Devolution/Empowerment Areas, the State Children's Health Insurance Program, and welfare reform. A listing of formal and informal organizational relationships is located in Appendix J.

Additional activities not mentioned previously in section 4.1 or section 1.5 include the family planning services provided by IDPH. Family planning activities are coordinated with the IDPH Family Planning Program and the Family Planning Council of Iowa, the Title X contractors for the state. For IDPH Title X clinic sites see Appendix P.

Other CSHCN Program activities not discussed in section 4.1, including the toll-free hotline, are detailed above in section 1.5.1.2. Also, a complete list of coordination-related programmatic agreements between CHSC and the Iowa Departments of Public Health (for general cooperation and Part C), Education (for SSI and Part C), and Human Services (for EPSDT, Home and Community-Based Services Ill and Handicapped Waiver, and Part C) appears above in section 1.5.2.

A number of other CHSC program activities should be mentioned.

- The Director is a member of the Clinical Advisory Committee and Chair of the CSHCN Subcommittee for the HAWK-I Board. In this capacity recommendations have been made to the board and the legislature regarding children with special health care needs;
- State and regional staff are involved with development of local boards for Community Empowerment Areas and have been involved closely in program planning and resource allocation in the local communities;
- The Director is working closely with the newly established College of Public Health at the University of Iowa to develop a Masters in Public Health in the Family and Child area;
- Several staff participate in planning and providing experiences for leadership training in the ILEND (Iowa Leadership Education in Neurodevelopmental Disorders) program. The Director is the co-director of the ILEND grant;
- CHSC jointly plans with the Iowa Departments of Human Services and Public Health to assure quality care for CSHCN enrolled in Medicaid Managed Care and SCHIP Programs;
- Two new regional centers are now operating – one in Des Moines serving central Iowa and another in the Johnson County area serving Cedar Rapids and the University of Iowa's Children's Hospital of Iowa;

- Staff collaborate with the Department of Public Health and the Iowa State University Extension Service to improve the leadership skills of community-based service providers under a CISS grant titled, "Health Leadership Iowa";
- Staff collaborate with the Department of Public Health and City MatCH (University of Nebraska) to plan a continuing education experience for Title V program leaders to build skills in data utilization and core public functions.
- Staff participate in planning and field-testing new approaches to delivering health care services and consultation to remote geographic sites using telemedicine techniques;
- Staff participate in constructing and implementing a long-range statewide public health blueprint titled, "Healthy Iowans 2010", which is modeled after "Healthy People 2010";
- CHSC has representation on the newly formed "Iowa Health Advocates" coalition which seeks to improve the ability of the public to effectively contribute to public health policy;
- Staff direct a statewide SPRANS grant project to create improved and innovative systemic approaches to transitioning CSHCN from school to successful employment and independent living; and
- A new reorganization of CHSC services into a decentralized modality is functioning to improve infrastructure building activities locally and regionally.

4.3 Public Input

The Iowa Department of Public Health continues with a strong network of groups in the preparation of the Title V Block Grant. Iowa's assessment of women, children and families' health care needs and planning for this application has been a collaborative process built on existing partnerships among consumers, providers, parents, and the public. The following outlines the input received for this application.

Iowa Maternal and Child Advisory Council. The MCH Advisory Council represents the spectrum of organizations concerned with MCH issues. The IDPH director appoints members. The council meets four times a year to recommend policy standards and to evaluate FSB and CHSC's progress in achieving goals. The council exists with two standing committees: the Maternal and Child Health subcommittee and the Children with Special Health Care Needs Subcommittee. The council was directly involved at many stages of the application process. During the past year committee membership was reviewed and by laws revised. Specifically, membership composition was changed to increase the number of parents represented on the Council. As referenced elsewhere, the council actively participated in and provided ongoing oversight for the development of this plan. Members were given an opportunity to comment and assist in the establishing of the

State Priority Needs and Performance Measure. The council endorsed the state plan at their June 15, 2000 meeting. See Appendix Q for a complete membership list and by-laws.

Family Services Bureau Grantee Committee. This ongoing committee is comprised of representatives from each of the 36 MCH and Family Planning contract agencies. FSB grantees are encouraged to provide input and influence policy and quality assurance activities within the Bureau. Additionally, the committee utilizes the newly formed subcommittees (allocation subcommittee, quality assurance subcommittee, and RFA subcommittee) to develop Title V program plans for the future. Input from the committee was used in determining the State Priority Needs and Performance Measures; feedback was received by members for the development of the State Plan.

Child Health Specialty Clinics. See section 3.2.1 for details regarding CHSC small group retreats.

Public Forum. A public forum was held May 24, 2000 to present the Title V application via ICN (Iowa Communication Network). The open forum was advertised by paid notices in the statewide newspaper. Announcements of the hearing were also made through the Family Services Bureau electronic mail, Program Update, which is available by e-mail or can be accessed on the World Wide Web. The Public Forum was conducted in collaboration with the WIC/Nutrition Bureau. The WIC/Nutrition Bureau presented their State Plan prior to the presentation of the Title V grant. A total of 10 participants were accounted for at the two hour ICN.

Parent Involvement. CHSC demonstrated a heightened commitment to family-centered services during its strategic planning process in early 2001 by choosing enhanced parent participation as one of six strategic direction initiatives for the year. A day-long retreat brought CHSC parent consultants from 13 regional office together on June 16, 2000 to begin the restructure of the CHSC Parent Consultant Network, with a central focus on parent participation at all levels of the organization. Information received from Title V programs in other states is being utilized to develop a best practice model.

During the last year, parent representative was increased on the MCH Advisory Council to three council members. A parent representative was selected to present at the Public Forum (see above). Ms. Julie Askren addressed the importance of family involvement and offered comments on strategies for further enhancing parent participation in the planning process. Additionally, Iowa's

Title V program works closely with parents involved with the state's Early ACCESS (early intervention) program to further enhance family centered approaches.

2000 Maternal and Child Health Conference. The planning committee for the annual MCH conference selected a core public health function as a theme for each year. Shared Leadership for the New Millennium – Changing Public Policy to Promote the Health of Iowa Families was the 2000 conference title which was held on April 6 and 7, 2000. Over 180 people participated in the conference and were asked to contribute to the collection of data for Iowa's MCH needs assessment.

4.4 Technical Assistance

See Form 15

FSB and CHSC request technical assistance for their joint project to carry out a population-based, household survey, State Systems Development Initiative (SSDI) Program MCH-19TO29, CFDA#93.110W, Iowa Children and Families: A Needs Assessment Household Health Survey. The guidance for FY 2000 Summary Progress Report for SSDI specified that the request for technical assistance should be included in the Title V block grant application.

The project is designed to: 1) evaluate the health status and health care needs of children and families in Iowa, 2) guide Title V program planning activities, and 3) develop policy recommendations to improve the health of children and families in Iowa. This population-based survey will provide needed data to help Iowa's MCH programs plan and prioritize program services and to provide baselines to assess future program performance.

FSB and CHSC request technical assistance for consultative staffing to analyze the data that will be collected as a result of the project. Peter C. Damiano, DDS, MPH, Director, Health Policy Research Program, Public Policy Center, is currently one of the project consultants for the SSDI project. Dr. Damiano will spend additional time analyzing the large amount of data for the Household Health Survey for the purpose of discovering additional MCH population based needs and suggesting further rational approaches to addressing those needs in conjunction with Title V program staff. As part of the analysis process, FSB and CHSC would direct Dr. Damiano to convene a panel of health care experts to make recommendations on how to maximize the use of the data.

FSB and CHSC are requesting technical assistance to pay the honorarium fee for Tawara Goode from Georgetown University Child Development Center to speak at the Fall MCH Conference on

Cultural Competence for MCH populations and children with special health care needs. The annual conference is October 5 and 6, 2000 in Iowa City.
FSB also requests technical assistance to pay tuition for designated persons to participate in the Data Use Academy starting in October 2000 and continuing through October 2001. The Data Use Academy is designed to build, enhance, and sustain the capacity of local public health agencies and their partners to use data effectively to improve maternal and child health (MCH) in America' s cities. In recent years the effective use of data has become more of a driver for agencies as public health shifts from health services delivery for their clients to population-based efforts. The Data Use Academy believes the ultimate key to being successful in using data effectively is to remember to focus on the results – improving the health of women, children, and families. The Data Use Academy will be a superb opportunity for the designated persons to learn more about the effective use of data.

The Title V program is attempting to provide leadership within DPH for the development of a comprehensive approach to women's health. While the department has several programs that address women's health from a categorical perspective, it lacks an integrated approach to assure that programs address women's health issues in a manner that gives full consideration across the life span. DPH requests technical assistance in the form of consultation for developing a blueprint that can serve as a guide to women's health programming.

SUPPORTING DOCUMENTS

5.1 GLOSSARY

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 % of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. ***(For planning and systems development)*** - Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional

conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women", "Infants", "Children with Special Health Care Needs", "Children", and "Others".

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a

common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians.. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family

support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the

income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.*[Title V, Sec. 501 (b)(2)]*

MCH Pyramid of Health Services - (see "Types of Services**")**

Measures - (see "Performance Measures")

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining:

1) What is essential in terms of the provision of health services;
2) What is available; and,
3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals

.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead

to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__. This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to

achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Belau.

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the

reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the ***Federal*** Title V Block grant allocation, the ***Applicant's*** funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance, the ***State*** funds (the total matching funds for the Title V allocation - match and overmatch), ***Local*** funds (total of MCH dedicated funds from local jurisdictions within the state), ***Other*** federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and ***Program Income*** (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

5.2 ASSURANCES AND CERTIFICATIONS

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply

to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18 Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about-

  (1) The dangers of drug abuse in the workplace;

  (2) The grantee's policy of maintaining a drug-free workplace,

  (3) Any available drug counseling, rehabilitation, and employee assistance programs; and

  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-

(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug=free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any

Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

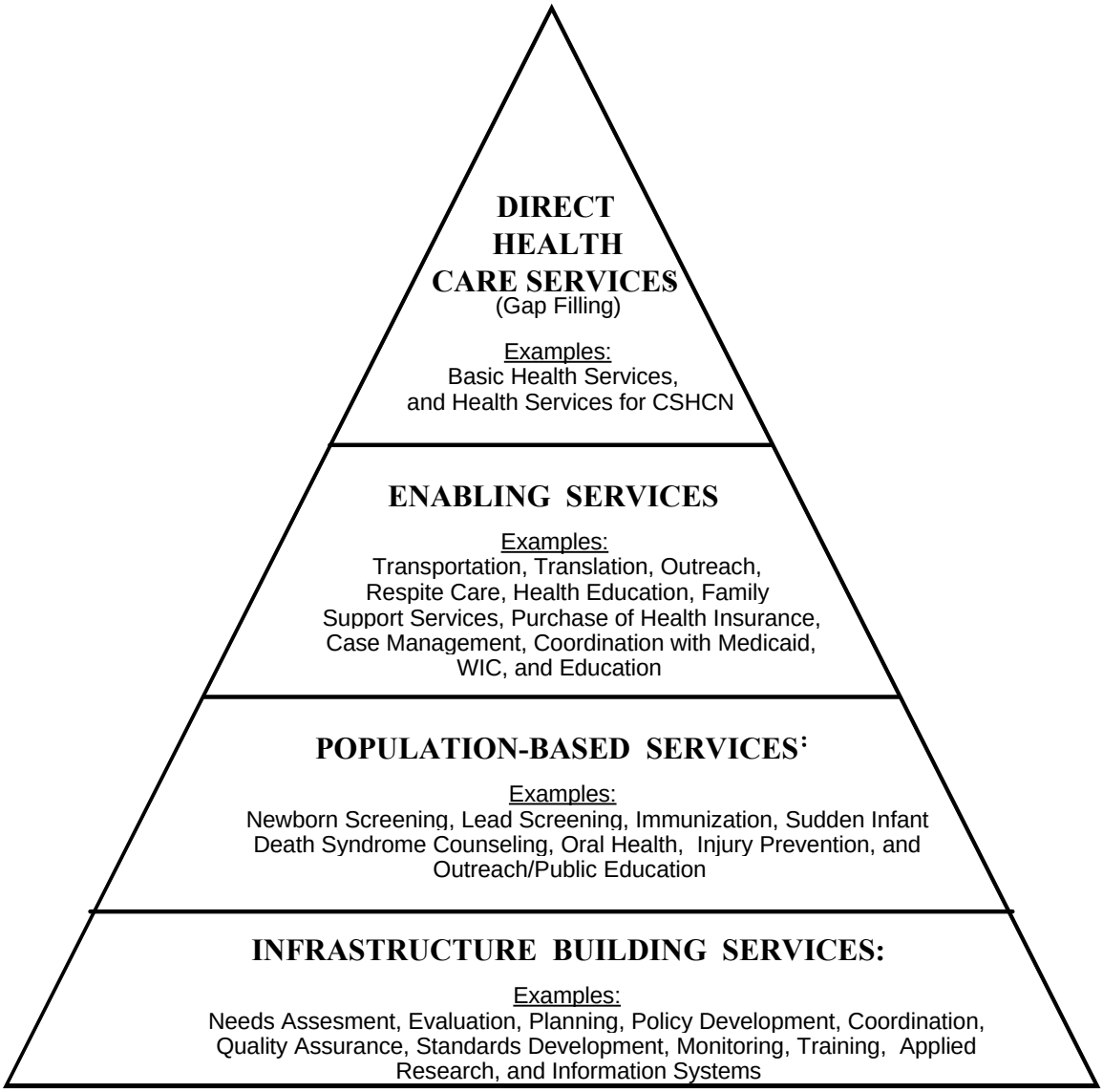
The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 OTHER SUPPORTING DOCUMENTS

APPENDICES

Figure 2

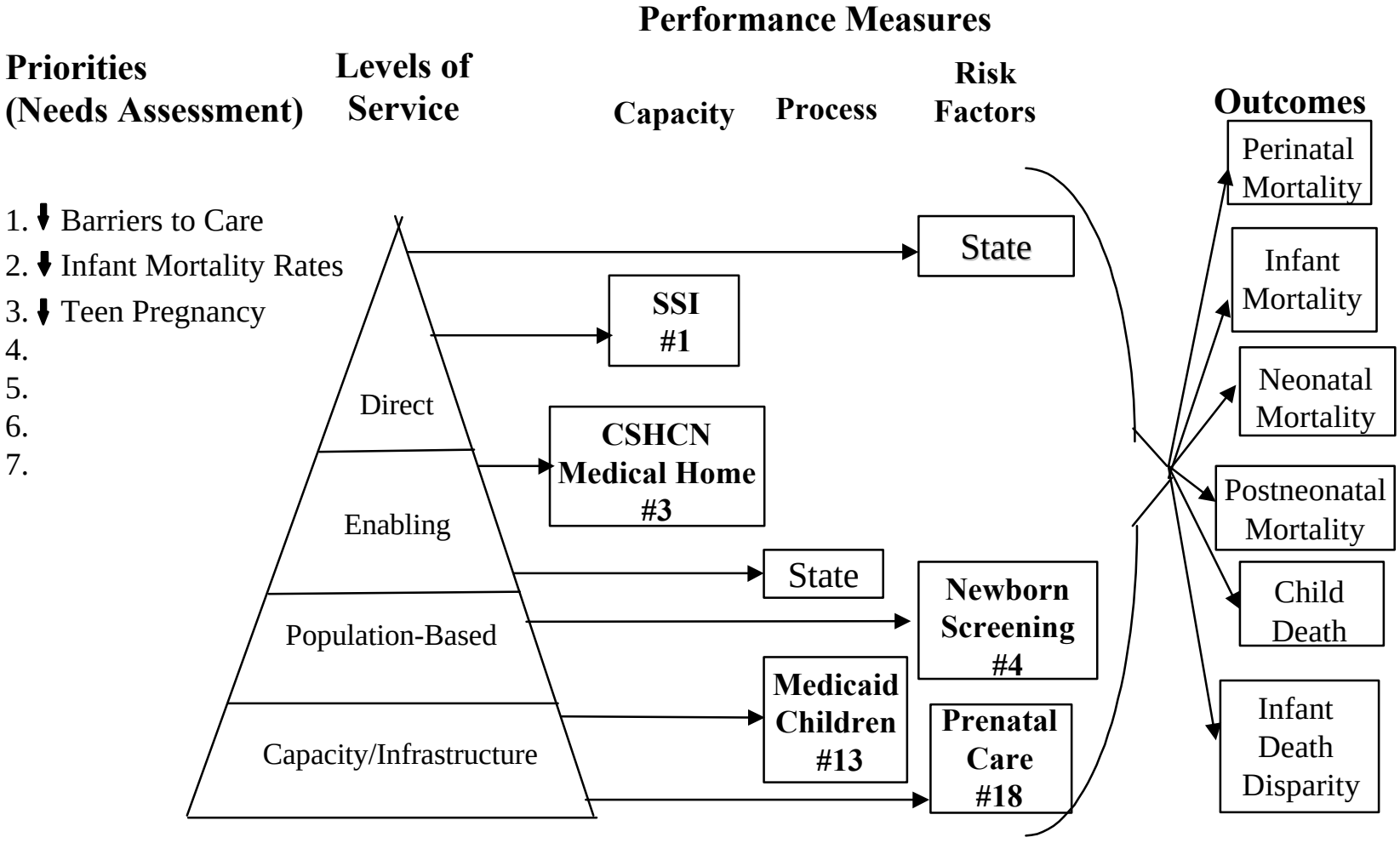
CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



H:MCHADV/pyramid.ppt (powerpoint) 3/98

Figure 3

Title V Block Grant
Performance Measurement System



*OSCH/MCHB 4/97 *PERFORMANCE MEASURE NUMBER(Examples Only)*

FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickcle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family				X		X	

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
participation in program and policy activities in the State CSHCN program							
15) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
16) Percent of very low birth weight live births				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

STATE PERFORMANCE MEASURES

State Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) Percent of children served under Title V and Title XIX who have a documented need for mental health/behavioral services who receive care from a service provider specializing in child and adolescent mental/behavioral health.	X				X		
2) Percent of women enrolled in Medicaid who received enhanced services during their pregnancy.	X						X
3) Percent of children served by Title V, excluding CSHCN, who report a medical home.		X			X		
4) Percent of low income children enrolled in child health centers who have completed a referral to a dentist.		X				X	
5) The percent of children with special health care needs enrolled in managed care plans who have a written plan of shared management protocols and protocol monitoring.		X			X		
6) Percent of children under age 1 year enrolled in Medicaid who receive care coordination services.		X			X		
7) The percent of infants identified in the state as high risk receiving follow-up (or appropriate discharge) at age 30 months.			X			X	
8) Degree to which key data are collected, managed analyzed, and utilized for strategic assessment of the determinates and consequences of the health status of women, children, and families.				X	X		

State Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
9) Degree to which Iowa's providers of general medical care services to CSHCN use quality improvement strategies in their practices.				X		X	
10) Percent of children and adolescents who are obese.				X			X
11) Percent of counties that report screenings and referrals for behavioral problems in young children.	X				X		
12) Percent of CSHCN enrolled in Title XIX Medicaid managed care or HAWK-I that have their needs identified and met.		X			X		
13) Percent of children estimated as being at-risk who receive monitoring and follow-up services at age 12 months.			X			X	
14) Ratio of black to white preterm births.			X				X
15)Percent of WIC clients, ages 2-5 years, that are overweight at or above the 95th percentile as defined by the PedNSS.			X				X
16) Percent of families of 1-year-old children enrolled in WIC who have participated in parenting education.				X		X	

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Related State Statutes

CODE OF IOWA-REFERENCE	*IOWA ADMINISTRATIVE CODE REFERENCE*	*TITLE*	*DESCRIPTION*
Chapter 136A	641-Chapter 4	Birth Defects Institute	All newborns shall be tested for hypothyroidism, phenylketonuria (PKU), galactosemia, branched chain ketoacidemia (MSUD), hemoglobinopathies, and congenital adrenal hyperplasia(CAH).
Chapter 135.4	641-Chapter 5	Maternal Deaths	All maternal deaths shall be reported to the maternal and child health bureau, Iowa Department of Public Health (IDPH) within 48 hours by the attending physician.
Chapter 139, 75GA, HF2145	641-Chapter 7	Immunization of persons attending elementary or secondary schools or licensed child-care centers	Specifies the required immunizations by age and required proof of immunizations.
Chapter 135.106, 72GA, HF169	641-Chapter 72	Lead Abatement Program	There is established a lead abatement program within the IDPH. The Department shall implement and review programs necessary to eliminate potentially dangerous toxic lead levels in children in Iowa in a year for which funds are appropriated to the department for this purpose.
Chapter 135	641-Chapter 73.10	Special Supplemental Food Program for Women, Infants, and Children (WIC)	The WIC program shall serve in the arrangement of ongoing health services for its participants. Health services are defined to include ongoing, routine pediatric and obstetrical care, and referral for diagnosis and treatment of any other condition. Local WIC agencies not able to provide such health services directly shall enter into written agreements with other public health agencies or private physicians to ensure availability of health services.
Chapter 234.21-.28	641-Chapter 74 441-Chapter 173	Family Planning Services	Mandated to enable persons who desire to obtain family planning care to have access to the requisite services, Congress authorized grants to assist in the establishment and operation of family planning projects which offer a broad range of acceptable and effective family planning methods, including natural family planning, infertility services and services to adolescents.
Chapter 255A	641-Chapter 75, 641-Chapter 82	Obstetrical and Newborn Indigent Patient Care	A statewide obstetrical and newborn indigent patient care program is established for the purpose of providing obstetrical and newborn care to medically indigent residents of this state. Appropriations by the general assembly for this chapter shall be allocated for the obstetrical and newborn patient care fund within the IDPH and shall be utilized for the obstetrical and newborn indigent patient care program as specified in this chapter.
Chapter 135L	641-Chapter 89	Decision-Making Assistance Program and Parental Notification of Intent to Terminate a Pregnancy Through Abortion	The program is intended to provide assistance to minors in making informed decisions related to pregnancy through the use of the video and written decision-making materials developed by the IDPH.
Chapter 144.29A	641-Chapter 106	Statistical Reporting of Termination of Pregnancy	A health care provider who initially identifies and diagnoses a spontaneous termination of pregnancy or who induces a termination of pregnancy shall file a report with IDPH.

Related State Statutes (Con't)

CODE OF IOWA-REFERENCE	*IOWA ADMINISTRATIVE CODE REFERENCE*	*TITLE*	*DESCRIPTION*
Chapter 137	641-Chapter 77	Local Boards of Health	The state health department shall receive the following information from the local board of health: names, addresses, and telephone numbers of members of the local board which shall be submitted within one month after their appointment; name of all officers elected within one month of election; board employee names addresses and telephone numbers, full or part-time status, and salaries within one month of employment; notice of employee discharge for any reason within one month; copy of the minutes of every board meeting which shall include at least the date and place, list of members present, and a report of any official board actions within one month of the meeting. In addition, an annual report of expenditures for the previous calendar year shall be submitted within 30 days of the county's fiscal year close.
Chapter 135	641-Chapter 76	Maternal and Child Health Program	The maternal and child health (MCH) programs are operated by the IDPH as the designated state agency pursuant to an agreement with the federal government. The majority of the funding available is from the maternal and child health block grant, administered by the United State Department of Health and Human Services. The purpose of the program is to promote the health of mothers and children by providing preventative, well child care services to low income children and prenatal and postpartum care for low income women.
Chapter 135.106, 74GA, Ch1001	641-Chapter 87	Iowa Healthy Families Program (Certified Nurse Midwives, and the Des Moines Infant Mortality Prevention Center)	The IDPH shall establish an Iowa healthy family program to provide services to families and children during the prenatal through preschool years. The program shall be assigned to promote optimal child development, improve family coping skills and functioning, and promote positive parenting skills and intrafamilial interaction with the goal of prevention of child abuse and neglect. The related appropriation language specifies the establishment of infant mortality and morbidity prevention pilot projects in three named counties. Research concerning the causes of individual infant deaths in the state shall be conducted. Midlevel practitioners shall be used to improve access to prenatal health care.
Chapter 135, 17A	641-Chapter 176	Criteria for Awards or Grants	The Department provides funds to a variety of entities throughout the state for the support of public health programs. The department considers that all funds, unless proscribed by appropriation language, the Iowa Code, Iowa Administrative Code or federal regulations, are subject to competition.
Chapter 135, Chapter 158	641-Chapter 201	Organized Delivery Systems	The following rules developed by the IDPH govern the organization and regulation of organized delivery systems, pursuant to the authority set forth by the Seventy-fifth General Assembly in Senate File 380 which can also be found in chapter 158 of the 1993 Iowa Acts.

Appendix A

Related State Statutes (Con't)

CODE OF IOWA-REFERENCE	*IOWA ADMINISTRATIVE CODE REFERENCE*	*TITLE*	*DESCRIPTION*
Chapter 249A	441-Chapter-78	Amount, Duration and Scope of Medical and Remedial Services	Details conditions for which DHS will pay for medical and health services which includes: screening centers, family planning clinics, maternal health centers, genetic consultation clinics, nurse midwives, and federally qualified health centers
Chapter 249A	441-Chapter 77	Conditions of participation for providers of medical and remedial care	Details licensing requirements for professionals, hospitals, pharmacies, other agencies or clinics that provide health services including maternal health centers, genetic consultation clinics, nurse midwives, federally qualified health centers and screening centers.
Chapter 249A	441-Chapter 84	Early and Periodic Screening, Diagnosis, and Treatment	The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program under Medicaid is an innovative model for the provision of health services to children. Its emphasis on preventive care and the importance of providing children with access to early and regularly scheduled well child examinations. New rules effective 8/1/95 will facilitate informing of clients about EPSDT and follow-up of referrals that result from screening.
Chapter 234	441-Chapter 163	Adolescent Pregnancy Prevention and Services to Pregnant and Parenting Adolescents Programs	Define and structure the grant programs for adolescent pregnancy prevention, services to pregnant and parenting adolescents, adolescent pregnancy prevention statewide campaign, adolescent pregnancy evaluation, and community adolescent pregnancy prevention programs. The services are to be provided to adolescents and their parents for the purpose of preventing adolescent pregnancy and to adolescents who are either pregnant or parenting to prevent subsequent pregnancies, promote self-sufficiency and physical and emotional well-being.
Chapter 235C	Rules Pending	Council on Chemically Exposed Infants and Children (CCEIC)	A CCEIC is established as a subcommittee of the committee on maternal and child health of the community health division of the IDPH. The purpose of the Council is to help the state develop and implement policies to reduce the likelihood that infants will be born chemically exposed, and to assist those who are born chemically exposed to grow and develop in a safe environment.
Chapter 641	641-Chapter -177	Health Data	The department is given the authority to collect health data for public health purposes, particularly hospital discharge data.
Chapter 141	641-Chapter 11	Acquired Immune Defficiency Syndrome (AIDS)	The IDPH is designated as the lead agency in the coordination and implementation of the state comprehensive AIDS related conditions prevention and intervention plan.

Related State Statutes (Con't)

CODE OF IOWA-REFERENCE	*IOWA ADMINISTRATIVE CODE REFERENCE*	*TITLE*	*DESCRIPTION*
Chapter 135.11	641-Chapter 170	Duties of the Department of Public Health	Administer the statewide maternal and child health program and the crippled children's program by conducting mobile and regional child health specialty clinics and conducting other activities to improve the health of low income women and children and to promote the welfare of children with actual or potential handicapping conditions and chronic illnesses in accordance with the requirements of Title V of the federal Social Security Act. The Department shall provide technical assistance to encourage the coordination and collaboration of state agencies in developing outreach centers which provide publicly supported services for pregnant women, infants, and children. The Department shall also, through cooperation and collaborative agreements with the department of human services and the mobile and regional child health specialty clinics, establish common intake proceeding for maternal and child health services. The department shall work in cooperation with the legislative fiscal bureau in monitoring the effectiveness of the maternal and child health centers, including the provision of transportation for patient appointments and the keeping of scheduled appointments.
Chapter 514 C.19	Rules Pending	Prescription Contraceptive Coverage – Family Planning	Modified to include contraceptive coverage to prescription benefits if persons have prescription benefits.
Chapter 505, Chapter 514H	191-Chapter 80	Health Coverage for Well Child Care	Relating to providing well child care under group accident and sickness insurance, group nonprofit health service plans, and prepare group plans of health maintenance organizations.
Chapter 514I.8	Rules Pending	HAWK-I	Expand eligibility by clarifying the definition of income and increasing the income limits in HAWK-I program from 185% FPL to 200% FPL.
Chapter 135	Rules Pending	Child Abuse	A review team shall be appointed to review the appropriateness of the actions by the organization involved with the child abuse case.
Chapter 1, 3	641-Chapter 175.13, 641-Chapter 175.14	Fair Information Practices and Public Records	The IDPH adopts, with the following amendments and exceptions, rules of the Governor's Task Force on Uniform Rules of Agency Procedure relating to public records and fair information practices which are printed in Volume I of the Iowa Administrative Code.
Chapter 279.51(3)	281-Chapter 66	School-Based Youth Services (SBYS)	The SBYS program funding was eliminated in the 2000 Legislative Session by House File 2496 Section 4.
Chapter 331.802	661-Chapter 21.1	Sudden Infant Death Syndrome Autopsies	If a person's death affects the public interest, the county medical examiner shall conduct a preliminary investigation of the cause and manner of death. The fee and expenses incurred for the investigation including the autopsy shall be paid by the state. A claim for payment shall be filed with the IDPH. Public interest, i.e. death of a child under the age of two years if death results from an unknown cause of if the circumstances surrounding the death indicate that SIDS may be the cause of death.

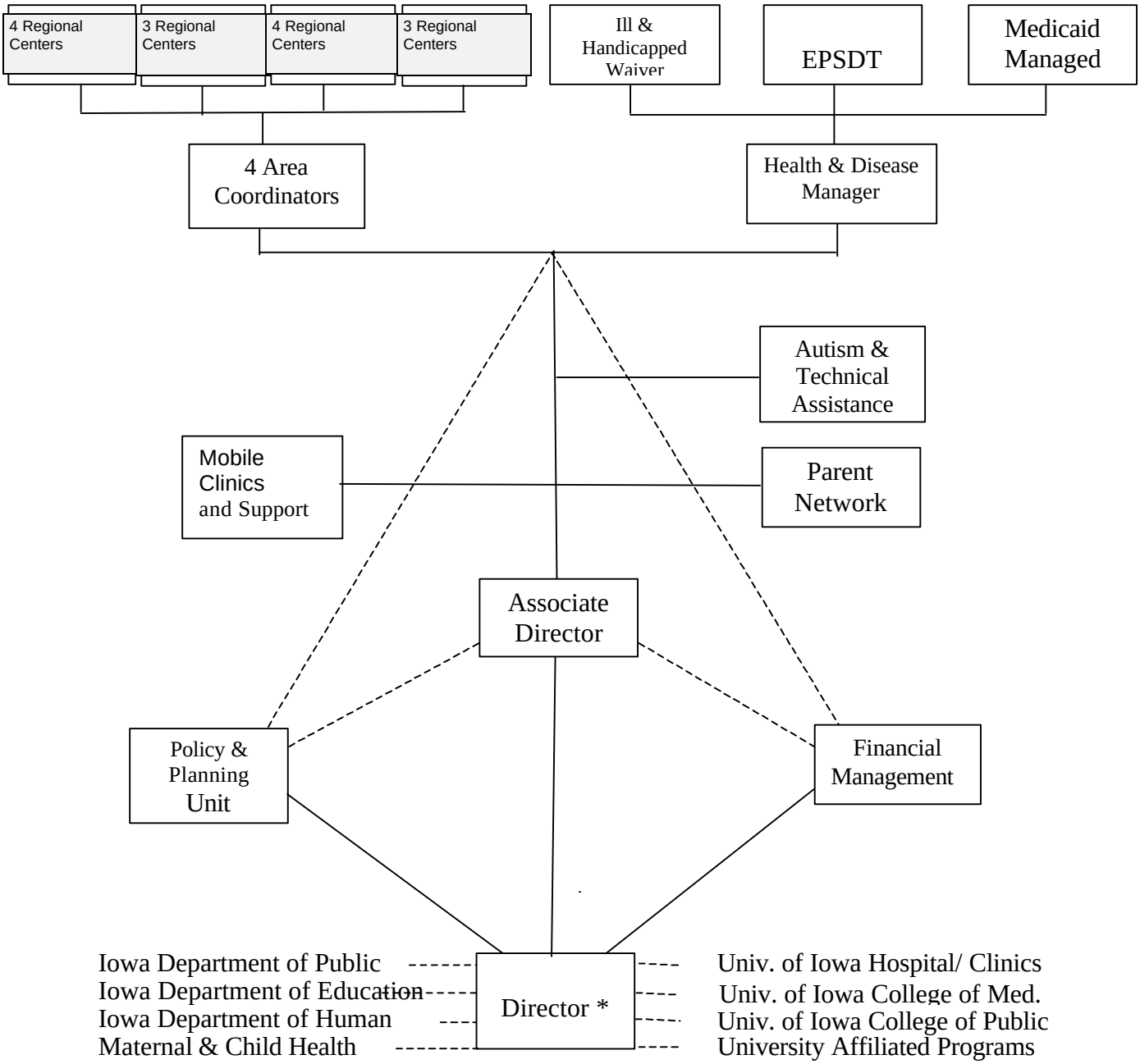
Related State Statutes (Con't)

CODE OF IOWA-REFERENCE	*IOWA ADMINISTRATIVE CODE REFERENCE*	*TITLE*	*DESCRIPTION*
Chapter 28E.4	Rules Pending	Agreement with other agencies	Any public agency of Iowa may enter into an agreement with one or more public or private agencies for joint or co-operative action pursuant to the provisions of this chapter, including the creation of a separate entity to carry out the purpose of the agreement.
Chapter 135	641-Chapter 191	Advisory Bodies of the Department	The department may from time to time establish an advisory body for the provision of advice or technical assistance in an identified area of public health.
Rules Pending	Rules Pending HF2365	Child Death Review	Expand Child Death Review to include children under the age of 18.
Rules Pending	Rules Pending HF2517	HAWK-I Child Health Insurance	Legislation establishes the state Title XXI child health insurance program.
Rules Pending	Rules Pending SF2406	Empowerment Areas	Establishes community empowerment areas, local empowerment boards and a state board.
Rules Pending	*Rules Pending HF402*	Establishment of Scope of Practice Review Committee/Midwives	Directs IDPH to receive applications and establish a Scope of Practice Review Committee to consider the regulation of direct-entry (non-nurse) midwives.
Rules Pending	*Rules Pending SF439*	Iowa Community Empowerment	Creates a Community Empowerment Office and funds administrative costs and staff, including a facilitator. Clarifies scope and duties of the Iowa Empowerment Board.
Iowa Administrative Code References are as follows: 191 = Insurance, 281 = Department of Education, 441 = Department of Human Services, 641 = Department of Public Health, 661 = Department of Public Safety			

Appendix A

Appendix B

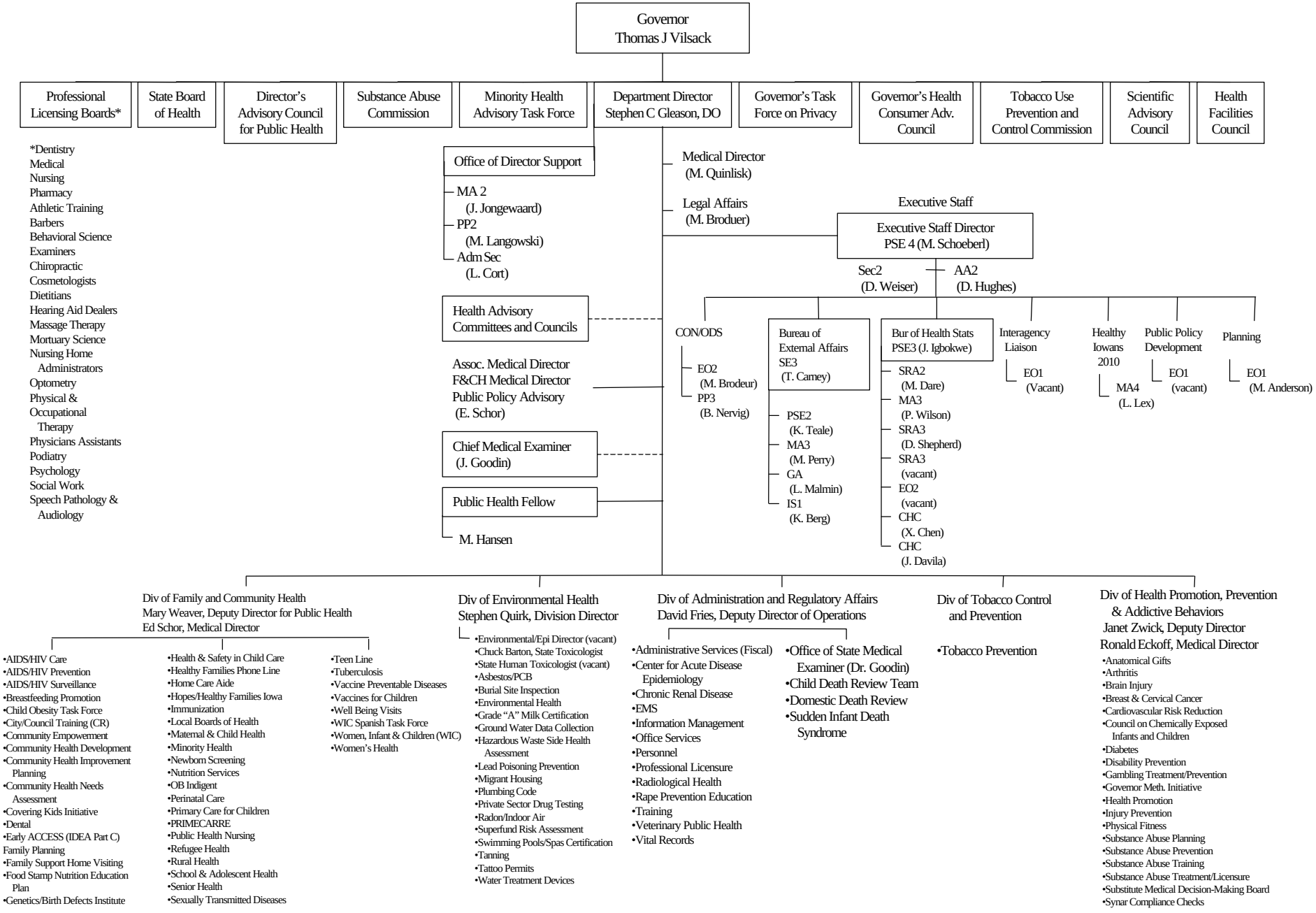
IOWA CHILD HEALTH SPECIALTY CLINICS
A Program of the Department of Pediatrics
The University of Iowa Hospitals and Clinics



* Collaborative relationship between CHSC director and external organizations.

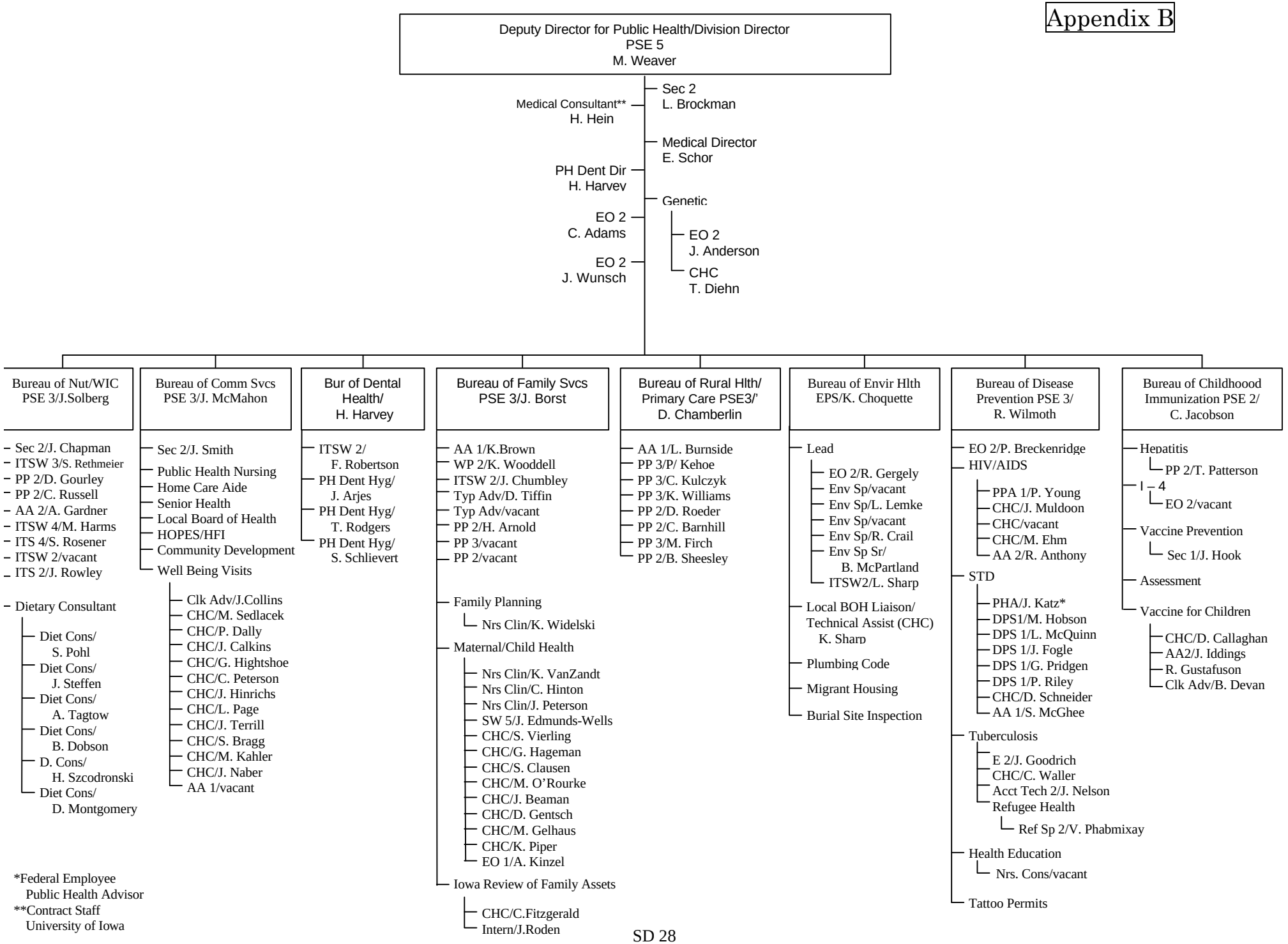
Iowa Department of Public Health

Appendix B



Family and Community Health

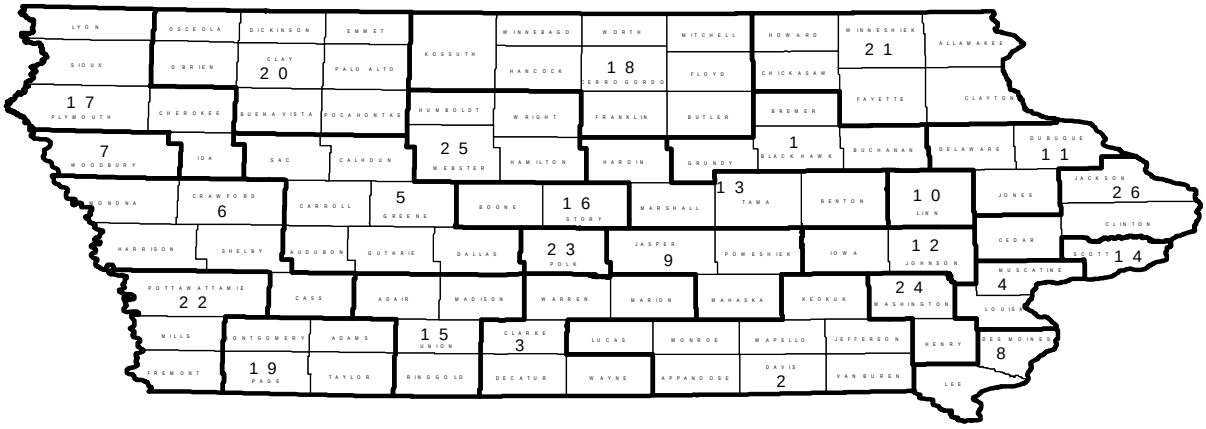
Appendix B



*Federal Employee
Public Health Advisor
**Contract Staff
University of Iowa

Appendix C

LOCATION OF MATERNAL HEALTH SERVICES



MATERNAL HEALTH SERVICES FUNDED BY THE IOWA DEPARTMENT OF PUBLIC HEALTH

1. **ALLEN MEMORIAL HOSPITAL**
   Women's Health Center
   233 Vold Drive
   Waterloo IA 50703
   319/235-5090

2. **AMERICAN HOME FINDING ASSOCIATION**
   Family Health Center
   317 Vanness Avenue
   Ottumwa IA 52501
   515/682-8784 / 800-452-1098

3. **COMMUNITY HEALTH SERVICES OF MARION COUNTY**
   104 South Sixth Street, P.O. Box 152
   Knoxville IA 50138
   515/828-2238

4. **UNITY HEALTH SYSTEM**
   1609 Cedar Street, 2nd Floor
   Muscatine IA 52761
   319/263-0122

5. **COMMUNITY OPPORTUNITIES, INC.**
   603 W. 8th Street
   Carroll IA 51401
   712/792-9266 / 800-642-6330

6. **CRAWFORD COUNTY HOME HEALTH & HOSPICE**
   105 N. Main (Courthouse Annex)
   Denison IA 51442
   712/263-3303

7. **CRITTENTON CENTER**
   1105 - 28th Street, P.O. Box 295
   Sioux City IA 51102-0295
   712/255-4321

8. **DES MOINES COUNTY HEALTH DEPARTMENT**
   522 North 3rd Street
   Burlington IA 52601
   319/753-8215

9. **GRINNELL REGIONAL MEDICAL CENTER**
   210 - 4th Avenue
   Grinnell IA 50112
   515-236-2273

10. **HAWKEYE AREA COMMUNITY ACTION PROGRAM, INC.**
    5560 - 6th Street, SW
    PO Box 789
    Cedar Rapids IA 52404
    319-366-7875

11. **HILLCREST FAMILY SERVICES**
    Hillcrest-Mercy Maternal Health Clinic
    102 Professional Arts, Mercy Drive
    Dubuque IA 52001
    319/589-8595

12. **JOHNSON COUNTY DEPARTMENT OF PUBLIC HEALTH**
    1105 Gilbert Court
    Iowa City IA 52240
    319/356-6045

13. **MARSHALLTOWN MEDICAL & SURGICAL CENTER**
    3 South 4th Avenue
    Marshalltown IA 50158
    515/752-1524

14. **MATERNAL HEALTH CENTER**
    852 Middle Road, #11369
    Bettendorf IA 52722
    319/359-6633

15. **MATURA ACTION CORPORATION**
    203 W. Adams Street
    Creston IA 50801
    515/782-8431

16. **MID-IOWA COMMUNITY ACTION, INC.**
    1001 South 18th Avenue
    Marshalltown IA 50158
    515/752-7162
    Story Co.: 515/292-1944

17. **MID-SIOUX OPPORTUNITY, INC.**
    418 Marion Street
    Remsen IA 51050
    712/786-2001 / 800-859-2025

18. **NORTH IOWA COMMUNITY ACTION ORGANIZATION**
    300 - 15th Street NE, P.O. Box 1627
    Mason City IA 50401
    515/423-5044 / 800-657-5856

19. **TAYLOR COUNTY PUBLIC HEALTH**
    MCH Center of Southwest Iowa
    407 Jefferson
    Bedford IA 50833
    712/523-3405

20. **UPPER DES MOINES OPPORTUNITY, INC.**
    101 Robbins Avenue, P.O. Box 519
    Graettinger IA 51342
    712/859-3885

21. **FINLEY TRI-STATE HEALTH GROUP, INC. VISITING NURSE ASSOCIATION**
    1454 Iowa Street
    PO Box 359
    Dubuque IA 52004
    319/556-6200

22. **VNA OF POTTAWATTAMIE COUNTY**
    300 West Broadway, Suite 10
    Council Bluffs IA 51503
    712/328-2636

23. **VISITING NURSE SERVICES**
    1963 Bell Ave., P.O. Box 4985
    Des Moines IA 50306-4985
    515/288-1516

24. **WASHINGTON COUNTY PHN SERVICE**
    314 McCreedy Drive
    Washington IA 52353
    319/653-7758

25. **WEBSTER COUNTY PUBLIC HEALTH**
    330 - 1st Avenue, North
    Fort Dodge IA 50501
    515-573-4107

26. **WOMEN'S HEALTH SERVICES**
    215 - 6th Avenue South
    Clinton IA 52732
    319/243-1413

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Division of Family and Community Health
Performance Standards

Performance Standards are the minimum criteria that contract agencies of the division must meet to assure a baseline level of quality services. Standards are requirements not philosophical guidelines. The Performance Standards will provide the framework for contract activities. **Each contract applicant will define in the contract application how they will meet the performance standards**. **Each contract grantee will demonstrate how the performance standards are met according to reporting requirements specified in the contract.** Specific target groups and methods will vary by Bureau.

Performance standards use the *Ten Essential Services of Public Health*[1] as a framework. Each performance standard contains five components:

1. The *Expected Result* is the anticipated outcome of the activities of the contractor. It is community focused.
2. *Tools and Infrastructure* are the structures and resources that must be available to a community to support the activities. A contractor does not have to supply the resources, but will need to work with other stakeholders to develop the capacity of the community to carry out the standard.
3. *Local Activities* are the actions carried out at the community level to meet the performance standard.
4. *State Activities* are the actions of the Department to support local activities.
5. *Evaluation* is the method by which the Department will determine if the contractor has met the performance standard.

The activities of the Performance Standards are to be coordinated with the local Board of Health. See Iowa Administrative Code 641-77 for authority of Boards of Health.

[1] As adopted in Fall 1994 by the Public Health Functions Steering Committee Members: American Public Health Association, Association of Schools of Public Health, Association of State and Territorial Health Officials, Environmental Council on States, National Association of County and City Health Officials, National Association of State Alcohol and Drug Abuse Directors, National Association of State Mental Health Program Directors, Public Health Foundation, U.S. Public Health Service-AHCPR, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Office of Assistant Secretary for Health, Substance Abuse and Mental Health Services Administration.

Performance Standards

Standard I
Participate in assessment and monitoring activities to identify population-based and environmental health assets and needs in Iowa communities.

Standard II
Identify, investigate, and monitor health events and health system effectiveness in the community.

Standard III
Convey information to the community regarding community health status, health care needs, positive health behaviors, health care policy issues, and environmental health issues.

Standard IV
Mobilize partnerships among groups and associations to foster the sharing of resources, responsibility, and accountability for assuring comprehensive, broad-based improvement of health status in the community.

Standard V
Participate in community planning activities that include policy makers, health care providers, the public, and others to promote family and community health initiatives to assure availability, accessibility, and acceptability of population-based, personal and environmental health services.

Standard VI
Promote regulations, standards, and contracts that protect the public's health and safety.

Standard VII
Link individuals and families to needed population-based personal health, environmental health and other community services; and assure the provision of care when otherwise unavailable.

Standard VIII
Assure the capacity of the public health, environmental health and personal health care work force to provide quality population-based care according to established standards and guidelines.

Standard IX
Evaluate the effectiveness, accessibility, and quality of population-based, personal health and environmental health services.

Standard X
Support innovative activities to gain new insights and solutions to family, community, and environmental health-related needs.

Essential Public Health Service 1: Monitor health status to identify community health problems				
Standard I **Participate in assessment and monitoring activities to identify population-based and environmental health assets and needs in Iowa communities.**				
Expected Result	**Tools and Infrastructure needed**	**Local Activities**	**State Activities**	**Evaluation Method**
Population-based assets and targeted public health needs including environmental health needs of the community are accurately described and are available for community planning. Data are collected in a systematic way that allows for comparison with other jurisdictions and provides information on trends over time. A method of analysis exists in the community that ensures validity of the information.	Community health planning team of members accepted by the community as defined in the contract application. Other planning entities, organizations, political groups, business groups. Accepted measures that are reliable, valid and comparable. Iowa Department of Public Health Community Assessment tool. Fiscal resources for data support. Community resource for data collection or analysis information.	Provide the leadership on a community planning team and/or with other community assessment activities for the target population or health issue specified in the contract. Enlist new partners for the planning team as appropriate. Assist with the collection of data and/or conduct surveys on health status, community assets, needs and barriers to health system utilization. Support a method for collection of data from accepted resources and various community entities, such as behavioral risk surveys, local disease outbreaks, occupational health, agricultural surveys, environmental studies, local institutional health reports, local public health department reports, and other data sources identified by the community	Assist with identification of reliable data resources and survey tools. Provide technical assistance for identifying appropriate assessment models. Provide technical assistance for facilitating group process as needed. Provide technical assistance and training for identifying methodologies and appropriate data reporting methods. Provide technical assistance and	Progress report describes activities and results with supporting evidence or summarizing documents as appropriate. Completed IDPH Community Health Needs Assessment and Health Improvement Plan submitted to IDPH.

Essential Public Health Service 1: Monitor health status to identify community health problems				
Standard I **Participate in assessment and monitoring activities to identify population-based and environmental health assets and needs in Iowa communities.**				
Expected Result	**Tools and Infrastructure needed**	**Local Activities**	**State Activities**	**Evaluation Method**
	Access to resources for data such as the Iowa Department of Public Health, University of Iowa, Iowa State University and other reliable sources.	team. Share data with the community health team or other planning entity. Actively participate with community health team to interpret and apply data. Allocate human and fiscal resources for data collection, analysis and dissemination.	training for data retrieval from state and national data resources.	

Essential Public Health Service 2: Diagnose and investigate health problems and health hazards in the community				
Standard II Identify, investigate, and monitor health events and health system effectiveness in the community.				
Expected Result	**Tools and Infrastructure Needed**	**Local Activities**	**State Activities**	**Evaluation Method**
Threats to the public's health and safety are recognized early and interventions are taken to thwart the continued exposure to injury and adverse health and environmental conditions.	A valid and reliable method for identifying trends. A system of emergency preparedness exists in the community. A system exists in the community for infectious, chronic, and environmental disease surveillance, investigation, and follow up.	Actively participate with a community team to interpret and analyze health data. Provide sound public health information regarding the target population or health issue specified in the contract. Monitor changes in population-based health status to track incidence, prevalence, or distribution of health problems such as communicable disease, failure to obtain recommended health care, injury, and environmental conditions.	Provide technical assistance to identify appropriate resources on use, analysis and interpretation of data. Monitor progress in community planning process. Interpret protocols and provide sound public health information for the investigation and intervention of public health and environmental health threats.	Progress report describes activities and results with supporting evidence or summarizing documents as appropriate. Site visit and/or progress report demonstrate that an appropriate data collection, analysis and dissemination method is in place and operational. Science-based protocols are on file at the agency to guide an immediate investigation, intervention and reporting of public health and environmental health threats.

Essential Public Health Service 2: Diagnose and investigate health problems and health hazards in the community				
Standard II Identify, investigate, and monitor health events and health system effectiveness in the community.				
Expected Result	**Tools and Infrastructure Needed**	**Local Activities**	**State Activities**	**Evaluation Method**
		Maintain science-based protocols to guide an immediate investigation and intervention of public health threats.		

Essential Public Health Service 3: Inform educate and empower people about health issues.

Standard III: Convey information to the community regarding community health status, health care needs, positive health behaviors, health care policy issues, and environmental health issues.

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Expected Result	Tools and Infrastructure	Local Activities	State Activities	Evaluation Method
Individuals and families make health behavior decisions based accurate information. Communities make health policy decisions based on accurate information. Population-based health status information is available in the community. Messages on the results of the data analysis are reported to the appropriate audiences in a timely fashion.	Resources for publicity and media campaigns Health education and marketing materials and processes that are culturally appropriate and reading level appropriate. Venues for health education. Local access to health education materials. Data is public domain and is in a central location that is easily accessed An electronic network that includes a web-site or bulletin board. Methods for	Provide population-based health education. Provide the leadership for development of health promotional materials for the contract specific population. Assure public access to current health status and system data. Source may be electronic or paper. Allocate human and fiscal resources for data dissemination.	Identify resources for health education methods and materials. Provide technical assistance on development of health education materials. Provide technical assistance and training on effective educational techniques. Facilitate collaboration among agencies and/or communities in the development of shared educational materials.	Progress report discusses health education activities with supporting evidence of process and impact. Site visit documents quality health curriculum is in place and education materials are appropriate

Essential Public Health Service 3: Inform educate and empower people about health issues.				
Standard III: Convey information to the community regarding community health status, health care needs, positive health behaviors, health care policy issues, and environmental health issues. **.**				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State Activities**	**Evaluation Method**
	dissemination of assessment information.			

Essential Public Health Service 4: Mobilize community partnerships to identify and solve health problems.				
Standard IV Mobilize partnerships among groups and associations to foster the sharing of resources, responsibility, and accountability for assuring comprehensive, broad-based improvement of health status in the community				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State** Activities	**Evaluation Method**
Improved health status of the population. Local groups and associations will work together to build the capacity of the local community to assure comprehensive health and environmental health services are available to individuals and families.	A comprehensive directory of local stakeholders. A community plan for communication and networking. Regular dialogue, shared values and mutual trust between partners.	Actively seek to strengthen linkages between local stakeholders Build stable partnership relationships in order to develop and maintain effective programs and strategies that promote family and community health. Obtain feedback from constituents and share relevant information with other stakeholders and local officials. Provide relevant information to community officials on matters involving the health of families in the community. Inform public officials about family and community health issues and progress toward local, state and federal health goals. Share in the activities of other community organizations as appropriate. Maintain a method of communication among local organizations.	Provide technical assistance for identification, development and sustaining of partnerships. Provide technical assistance/training for leadership and advocacy skills.	Progress report describes activities and results with supporting evidence or summarizing documents as appropriate.

Essential Public Health Service 5: Develop policies that support individual and community health efforts				
Standard V Participate in community planning activities that include policy makers, health care providers, the public, and others to promote family and community health initiatives to assure availability, accessibility, and acceptability of population –based, personal, and environmental health services.				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State** Activities	**Evaluation Method**
Community priorities are the basis of the community health plan. Solutions are described for meeting the community needs using the data analysis, study of the contributing factors and the community's assets. A community plan is accepted by the community that describes the activities to carry out the plan, the responsible party for implementation of the activities, and a timeline for completion.	Community health planning team, other planning entities, organizations, political groups, or business groups. A generally recognized planning model. Mechanisms for routine communication between team members. Indicators, performance measures, benchmarks, the Year 2010 Objectives, Healthy Iowans 2010 and other	Promote compatible, integrated service system initiatives that are family centered. Provide sound public health information regarding contract specific population or health issue to local planning efforts. Develop program action plans within the local agency that support the community plan. Assure that priorities established are congruent with the local needs assessment, the MCH State Plan, Healthy Iowans 2010, IDPH needs assessment, and the local Empowerment Area plan. Assure inclusion of families and family centered priorities in the community plan. Assure that environmental health services are included in the plan. Identify the local resources for solving specific issues. Support appropriate planning methods for the development of the community plan.	Provide technical assistance/training for resource identification and use. Provide technical assistance/training for improvement of community planning skills.	The community plan submitted with the contract progress report clearly documents participation in a community planning team, identifies the methods for carrying out the plan of action, and clearly demonstrates that the established community priorities are the basis for the activities. A community plan is on file at the Department of Health. Priorities established are congruent with the local needs assessment, Healthy

Essential Public Health Service 5: Develop policies that support individual and community health efforts				
Standard V Participate in community planning activities that include policy makers, health care providers, the public, and others to promote family and community health initiatives to assure availability, accessibility, and acceptability of population –based, personal, and environmental health services.				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State** Activities	**Evaluation Method**
The community has policies that assure health care access for all individuals and that improve the health of the population. The community has policies that assure access to environmental health services to improve the community and the population.	documents that provide state and national objectives.	Develop the system linkages for communication and implementation of the plan. Support and allocate agency resources for the activities of the plan. Support and promote public advocacy for policies, legislation, and resources to assure access to appropriate health services. Regularly communicate with local, state and federal elected officials advocating for women, children and their families.		Iowans 2010, IDPH needs assessment and the Empowerment Area plan.

Essential Public Health Service 6: Enforce laws and regulations that protect health and ensure safety.				
Standard VI Promote regulations, standards, and contracts that protect the public's health and safety				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State Activities**	**Evaluation Method**
Local, state, and federal standards, guidelines, regulations, and contract specifications address local level issues and concerns. Adopted policies, regulations, standards and contracts that protect the public's health are an integral part of operating program procedures. Policymakers have a link to the local community for expertise in the contract specific field. There is a recognized community resource for the interpretation of program specific regulations.	Local Board of Health Written documents and procedure manuals explaining regulations and standards related to the contract specific population or health issue. Mechanisms for training health personnel and the public. Public forums with elected officials and appointed public officials. Internet access to state and federal laws and regulations.	Follow local, state, and federal standards, regulations, and guidelines in the operation of contract services. Educate entities or community groups about the intent and means for implementing policies and regulations as they pertain to target groups of the contract. Regularly participate in the development, review, and updating of standards, guidelines, regulations, and public contract specifications Provide expertise and resources to support advocacy services. Provide information to individuals and families	Interpret state and federal regulations and standards. Provide technical assistance for the identification of resources Inform contract agencies of current legislative and regulatory activities. Seek local expertise in the development of state level policies, rules and regulations. Provide expertise and identify resources to support local activities. Advocate for state and federal regulatory changes that will reduce barriers to care.	Progress report identifies areas of involvement with supporting evidence or a summarizing documents as appropriate. Site visit determines that contract agency and subcontractors meet regulations, standards and contract specifications.

Essential Public Health Service 6: Enforce laws and regulations that protect health and ensure safety.				
Standard VI Promote regulations, standards, and contracts that protect the public's health and safety				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State Activities**	**Evaluation Method**
		who seek to file grievances or appeals regarding personal or environmental health services.		

Essential Public Health Service 7: Link people to needed personal health services and assure the provision of care when otherwise unavailable.				
Standard VII Link individuals and families to needed population-based, personal health, environmental health and other community services; and assure the provision of care when otherwise unavailable.				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State Activities**	**Evaluation Method**
Individuals and families use health services available in the region and state. Individuals and families use comprehensive personal health services that are family-centered and culturally appropriate. Individuals and families use environmental health services available in the region and state.	A system for communication and networking between health service providers, social service and education providers. Marketing materials and processes that are culturally appropriate and reading level appropriate. Formalized referral and feedback mechanisms Central public location or resource (i.e. telephone or web page) for information and referral activities. Local system of comprehensive personal and environmental health services Community plan for the coordination of health services and reduction of barriers to care.	Promote the utilization of existing local services and providers, including publicly funded health insurance. Participate in state and local advocacy and system coordination efforts. Assure outreach service to the uninsured and hard to reach populations. Assure culturally appropriate information to promote access to primary health care services, utilizing a variety of mechanisms and locations. Establish a system of linkages with other providers of service to avoid gaps in care. Assure access to individual primary health care services not otherwise available through health plans or local providers. Assure comprehensive	Encourage creative strategies by removing policy and regulatory barriers when possible. Promote the development of statewide or regional subcontracts with health plan or provider networks or public assistance programs including Medicaid. Provide the leadership and resources for innovative, non-traditional methods of care delivery. Provide leadership and resources for innovative methods of environmental health service	Progress report demonstrates activities with supporting evidence or summarizing documents as appropriate. EPSDT participation rate is at or above 80%. Program goals related to participation in health services are met or exceeded. Data on use of health service funds indicates individuals and families are using services appropriately HAWK-I (CHIP)

Essential Public Health Service 7: Link people to needed personal health services and assure the provision of care when otherwise unavailable.				
Standard VII Link individuals and families to needed population-based, personal health, environmental health and other community services; and assure the provision of care when otherwise unavailable.				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State Activities**	**Evaluation Method**
	Contracts with community health care providers. System of support services such as transportation, translation services and childcare.	environmental services are available in the community. Develop agreements with other partners that are family centered and improve accessibility to community services. Include support services such as transportation, translation and childcare. Together with other community partners participate in and support recruitment and retention of local primary care providers	delivery.	participation rates are at or above the goal.

Essential Public Health Service 8: Assure a competent public health and personal health care workforce.				
Standard VIII Assure the capacity of the public health, environmental health, personal health care work force to provide quality health care according to established standards and guidelines.				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State Activities**	**Evaluation Method**
Local public health, environmental health and personal health care work force participates in educational opportunities to maintain competencies required for providing quality health services according to established standards and guidelines. Local public health, environmental health and personal health care workforce maintains professional credentials. Local program support staff and paraprofessionals exhibit job appropriate competencies.	Communication network between professional health service providers, institutions or professional organizations that provide educational opportunities Curriculum Expertise in the competency to be taught. Fiscal and human resources to provide training for staff. Mechanisms for training public health, personal health care, and environmental health personnel.	Provide orientation and training for local public and environmental health personnel such as program staff, school health personnel, child care providers, care coordinators/case managers, home visitors, home health aides and respite workers, community outreach workers, and sanitarians. Provide technical assistance, consultation, and resources for target population or health issue specified in contract to other local institutions and organizations for education of personnel. Assist in the development of continuing education programs for professional organizations. Secure /retain staff in the local contract agency with expertise in, business administration, quality improvement, health policy development, information systems, community systems building	Identify resources for or conduct training of contract agency professionals on new and emerging public health, health care, and environmental health issues.	Agency provides written assurance of credentials and training and retains documentation to be available for review at site visit. Site visit verifies professionals have appropriate credentials. Site visit verifies that support staff and paraprofessionals have received required training.

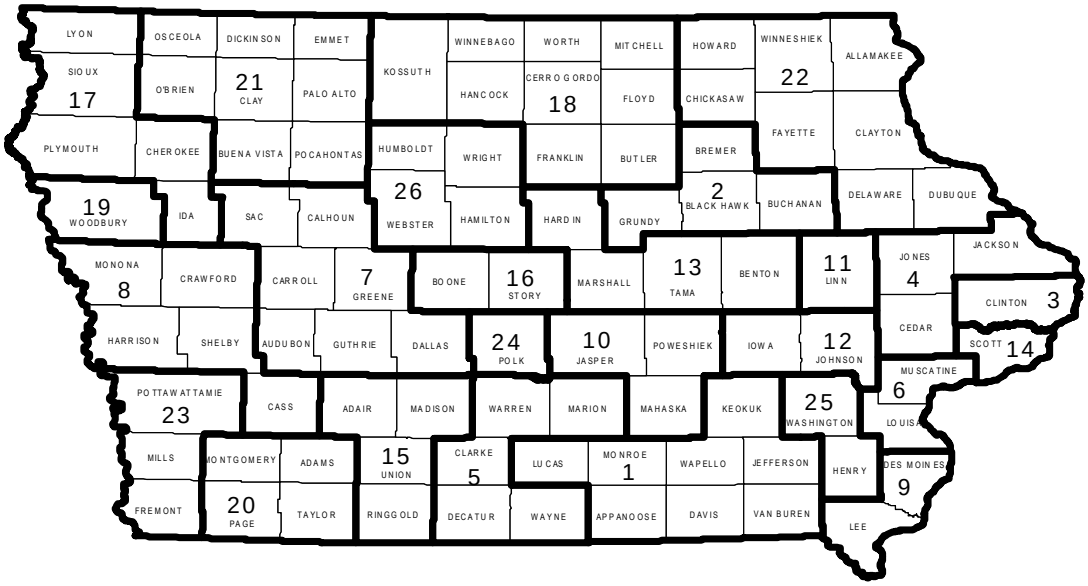
Essential Public Health Service 8: Assure a competent public health and personal health care workforce.				
Standard VIII Assure the capacity of the public health, environmental health, personal health care work force to provide quality health care according to established standards and guidelines.				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State Activities**	**Evaluation Method**
		activities, and clinical care. Provide or support training opportunities for all agency staff.		

Essential Public Health Service 9: Evaluate the effectiveness, accessibility, and quality of personal and population-based health services.				
Information from the evaluation process is used to refine existing community health programs, establish new ones and, if needed, to redirect resources to accomplish program goals. Personal, population-based, and environmental health services are accessible and effective. Data is available on access to care in the community. Data is available on quality of personal, population-based, and environmental	A comprehensive system of quality health services that is family centered, community based, culturally appropriate, accessible and effective (includes prevention and intervention, laboratory services, and environmental services). Benchmarks, laws, regulations, and local policy. Community evaluation plan based on the needs assessment and community plan. Self-assessment tools to monitor the community plan of action. Quality assurance tools. Quality standards for service Method for evaluating consumer satisfaction that	Monitor and evaluate the accessibility, effectiveness, cultural competency and quality of personal health, population-based and environmental health services within the local contract agency. Together with community partners monitor and evaluate the accessibility, effectiveness, cultural competency, and quality of personal health and population-based health services in the community. Advocate for policy changes to support community needs identified in evaluation. Monitor community health planning strategies, and regularly provide evaluation information to the appropriate community planning and policy development committees. Provide leadership to assure the capacity of the community to obtain information on the local population's perceptions of service needs.	Provide technical assistance and training in defining, measuring, and evaluating practices. Provide technical assistance for data analysis and interpretation for systems changes. Assist in the identification of appropriate population survey tools and methods. Provide data and evaluation examples from other communities and states. Compile community-level information on health and environmental health needs to augment planning and policy development at the state and national levels. Develop, monitor and	Progress report describes activities and results with supporting documentation. Results of consumer survey indicate families are able access program services and community support services. Survey results indicate consumer satisfaction with the services. Goals of the community plan are revised to reflect the results of the evaluation as appropriate. Goals of the community plan are met.

Essential Public Health Service 9: Evaluate the effectiveness, accessibility, and quality of personal and population-based health services.				
health services.	includes access to community support services.	Utilize program specific data systems, i.e. MCH data system, EPSDT, WIC, and lead data system.	provide technical assistance on utilization of contract specific data systems.	

Essential Public Health Service 10: Research for new insights and innovative solutions to health problems.				
Standard X **Support innovative activities to gain new insights and solutions to family, community, and environmental health-related needs.**				
Expected Result	**Tools and Infrastructure**	**Local Activities**	**State Activities**	**Evaluation Method**
New ideas and innovative practices improve public health, health care, and environmental health services in the community.	Collaborative community partnerships with local learning institutions and other community-based organizations such as senior citizen organizations, childcare, and service organizations. Access to funding sources that encourage innovation. Access to staff or consultants with grant writing skills Community needs assessment documenting the need for the innovation.	Actively identify projects that will address community priorities as identified in the community/ agency assessment or evaluation of services. Initiate and seek support for innovative community projects. Disseminate information about innovative activities, including what worked and what did not work.	Encourage, allocate resources or provide technical assistance for innovative approaches to health services. Assist with the identification of resources and tools for assessment, implementation and evaluation. Identify and publicize "best practices" Provide resources for identification of funding opportunities.	Progress report describes activities with supporting documentation or summarizing documents as appropriate. Documentation that new or innovative services are adopted by the agency or within the community.

LOCATION OF CHILD and ADOLESCENT HEALTH SERVICES



CHILD AND ADOLESCENT HEALTH SERVICES FUNDED BY THE IOWA DEPARTMENT OF PUBLIC HEALTH

1. **AMERICAN HOME FINDING ASSOCIATION***
   Family Health Center
   317 Vanness Avenue
   Ottumwa IA 52501
   515/682-8784 / 800-452-1098
2. **BLACK HAWK COUNTY CHILD HEALTH CENTER***
   1407 Independence Avenue
   Waterloo IA 50703
   319/291-2661
3. **CLINTON COUNTY BOARD OF HEALTH**
   329 East 11th Street
   DeWitt IA 52742
   319/569-8148
4. **COMMUNITY HEALTH OF JONES COUNTY**
   104 Broadway Place
   Anamosa IA 52205
   319/462-6131 ext. 332
5. **COMMUNITY HEALTH SERVICES OF MARION COUNTY**
   104 South Sixth Street, P.O. Box 152
   Knoxville IA 50138
   515/828-2238
6. **UNITY HEALTH SYSTEM**
   1609 Cedar Street
   Muscatine IA 52761
   319/263-0122
7. **COMMUNITY OPPORTUNITIES, INC.**
   603 W. 8th Street
   Carroll IA 51401
   712/792-9266 / 800-642-6330
8. **CRAWFORD COUNTY HOME HEALTH & HOSPICE**
   105 North Main, Courthouse Annex
   Denison IA 51442
   712/263-3303
9. **DES MOINES COUNTY HEALTH DEPARTMENT**
   522 N. 3rd Street
   Burlington IA 52601
   319/753-8215
10. **GRINNELL REGIONAL MEDICAL CENTER**
    210 - 4th Avenue
    Grinnell IA 50112
    515/236-2273
11. **HAWKEYE AREA COMMUNITY ACTION PROGRAM, INC.**
    5560 - 6th Street, SW
    PO Box 789
    Cedar Rapids IA 52404
    319/366-7875
12. **JOHNSON COUNTY DEPARTMENT OF PUBLIC HEALTH**
    1105 Gilbert Court
    Iowa City IA 52240
    319/356-6045
13. **MARSHALLTOWN MEDICAL AND SURGICAL CENTER**
    3 South 4th Avenue
    Marshalltown IA 50158
    515-752-1524
14. **MATERNAL HEALTH CENTER**
    852 Middle Road, #11369
    Bettendorf IA 52722
    319/359-6633
15. **MATURA ACTION CORPORATION**
    203 W. Adams Street
    Creston IA 50801
    515/782-8431
16. **MID-IOWA COMMUNITY ACTION, INC.**
    1001 South 18th Avenue
    Marshalltown IA 50158
    515/752-7162
    Story Co.: 515/292-1944
17. **MID-SIOUX OPPORTUNITY, INC.**
    418 Marion Street
    Remsen IA 51050
    712/786-2001 / 800-859-2025
18. **NORTH IOWA COMMUNITY ACTION ORGANIZATION**
    300 - 15th Street NE, P.O. Box 1627
    Mason City IA 50401
    515/423-5406 / 800-657-5856
19. **SIOUXLAND COMMUNITY HEALTH CENTER**
    P.O. Box 2118
    Sioux City IA 51104-0118
    712/252-2477
20. **TAYLOR COUNTY PUBLIC HEALTH MCH Center of Southwest Iowa**
    407 Jefferson
    Bedford IA 50833
    712/523-3405
21. **UPPER DES MOINES OPPORTUNITIES, INC.**
    101 Robbins Avenue, P.O. Box 519
    Graettinger IA 51342
    712/859-3885
22. **FINLEY TRI-STATE HEALTH GROUP, INC.**
    VISITING NURSE ASSOCIATION
    1454 Iowa Street
    P.O. Box 359
    Dubuque IA 52004
    319/556-6200
23. **VNA OF POTTAWATTAMIE COUNTY**
    300 W. Broadway, Suite 10
    Council Bluffs IA 51503
    712/328-2636
24. **VISITING NURSE SERVICES**
    1111 - 9th Street, P.O. Box 4985
    Des Moines IA 50306-4985
    515/288-1516
25. **WASHINGTON COUNTY PHN SERVICE**
    314 McCreedy Drive
    Washington IA 52353
    319/653-7758
26. **WEBSTER COUNTY PUBLIC HEALTH**
    330 First Avenue, North
    Fort Dodge IA 50501
    515/573-4107

*Child & School based clinics

Updated March 14, 2001 H:chmap.doc

Iowa Child Death Review Team
Recommendations for Prevention of Future Deaths
December 1999

The public saw a few newspaper headlines in 1998 about children's deaths, but the fact that 332 young Iowans, ages six and under, died in 1998 went largely unnoticed. That is tragic because many of these deaths were preventable

The Iowa Child Death Review Team (CDRT) is chartered to review the deaths of all children, ages six and under, and to present to the governor, legislature, and state agencies suggestions on how to make Iowa safer for children. This report provides statistical data on the deaths of the 332 youngsters and presents ideas to help lower the number of deaths. Several of our suggestions are repeats from previous reports, but they remain as viable as ever. Most relate to improved reporting and investigating that will allow the CDRT to make even better recommendations in the future based on better information.

It is our hope that with the assistance of Iowa Department of Public Health, our recommendations will result in a decline in the number of deaths of our children as we begin a new millennium. Some of the recommendations were made in the past three annual reports, but were not acted upon. Reviews from 1998 deaths showed that these recommendations continue to be viable suggestions for saving the lives of Iowa's children, and so they are again included in our annual report and are noted as having been made in previous years.

Recommendations to the Governor and the Iowa General Assembly

Recommendation 1. The Child Death Review Team recommends mandatory use of Iowa's Infant Death Scene Investigation Protocol and Report Form by all county medical examiners in cases of infant death where the cause of death is suspected as SIDS or is undetermined at the time that the death occurs. The county medical examiner should be required to file this standardized Infant Death Scene Investigation form along with the M.E.I report in the State Medical Examiner's Office within four weeks following the child's death.

Recommendation 2. The CDRT recommends expansion of the Community Empowerment Initiative so that it may eventually be implemented throughout Iowa. The CDRT especially advocates implementation of Community Empowerment Initiatives that devote approximately 60% of their funds to home visits for all families with a newborn child so that each family may become educated in appropriate health and welfare

practices relating to infants and young children. Education and mentoring of this type may ultimately result in a reduced number of deaths of Iowa children that are a consequence of inappropriate or inattentive parental supervision and care. The CDRT further recommends that an annual increase of funding in the amount of $5 million per year be allocated tot he Empowerment Initiative until all areas of the state are involved in a local empowerment program of assessment and action.

Recommendation 3. (This recommendation was also made in the January, 1997 and 1998 reports.) The CDRT recommends establishment of a statewide system of local or regional child death review teams, which would review deaths of all children through age six and share their findings and information with the state team. It is further recommended that these teams be permitted the same statutory authority given to the state CDRT to gather and review information related to child deaths. The CDRT proposes that the team establish contacts in Iowa counties (Black Hawk, Johnson, Linn, and Pottawattamie) which have consistently had ten or more child deaths annually but have not yet established a local or regional child death review system, to discuss the need for a local review team. Contacts by the CDRT of these counties was recommended in the December 1998 report. Representatives from Linn, Black Hawk, and Pottawattamie counties met with the CDRT teams members and representatives from the four established local teams in January 1999. Johnson county sent no representatives to the meeting. Members of the state CDRTand of the existing local teams shared procedures that their teams follow. Members of the CDRT explained the advantages of establishing a local team, reasons to expand current teams purviews to cover child deaths through age six and potential outcome if local teams existed. The CDRT pledged on-site and telephone assistance to the local entities that are willing to implement their own review system and cooperatively share information.

It is further recommended that communities that have either established their own local child death review team or that participate in a regional team be given extra points during review of their application for Community Empowerment funds. A thorough understanding of the causes and types of child deaths in an area may help identify needs to be addressed when developing a Community Empowerment Program aimed at infants and young children.

Recommendation 4. (This recommendation was made in the December 1998 report.) The CDRT recommends raising the fine for driving with an improperly restrained child under six years of age in a motor vehicle to $100. Stricter penalties and enforcement of this magnitude of a fine should help deter drivers from having improperly restrained children in their moving vehicles and would not necessitate an accident before the issue of prevention is addressed by law enforcement.

Recommendation 5. (This recommendation was also made in the January, 1997 and 1998 and December, 1998 reports.) The CDRT recommends that the performance of an autopsy including toxicology studies be required for every death of a child through age six with the exception of children who are known to have died of a disease process while attended by a physician. In addition, we recommend full body x-rays of the bodies of

children who die before their second birthday, and immediate drug screens of caretakers and people having access to the child prior to the death.

Recommendation 6. (This recommendation was also made in the December 1998 report.) The CDRT recommends the performance of cotinine (a metabolite of nicotine) testing on all infants who die in Iowa to accurately determine the potential role of tobacco exposure as a risk factor in their deaths. It is suggested that funding for this testing should come from state taxes on tobacco products. This information would prove invaluable in planning and directing future anti-smoking education efforts statewide, and more accurately assessing the influence that tobacco exposure has on Iowa's infant mortality rate.

Recommendations To State Agencies

Recommendation 1 - *to the Iowa Department of Public Health Bureau of Vital Records.* The CDRT recommends that efforts be ongoing and increased to educate those individuals responsible for completing and filing death certificates in their responsibilities and the need for accurate and complete information and timely filing. The team further recommends that available sanctions be enforced for individuals who fail to adequately perform these duties. (This recommendation was also made in the January, 1997 and 1998 and December, 1998 reports.)

Recommendation 2 – *to the Office of the State Medical Examiner.* The CDRT recommends increased efforts to obtain from attending physicians and county medical examiners timely, complete, and accurate information on autopsies, death certificates, and amendments. (This recommendation was made in January, 1997 and 1998 and December, 1998 reports.)

Recommendation 3 - *to the Iowa Department of Human Services, Office of Field Support.* When a child dies due to a parent's or a caretaker's ignorance, neglect or aggression, the CDRT recommends that ongoing efforts be made to visit the surviving children in the home within one month to assess the safety and well-being of these children and enable voluntary referrals to appropriate services. This visit is to be completed by DHS caseworkers knowledgeable in family dynamics and child abuse/neglect. (This recommendation was also made in the January, 1997 and 1998 and December, 1998 reports. Although it is again reiterated in this year's report, it is recognized that the Iowa Department of Human Services has made great progress in addressing this issue. The assessment approach is now being used statewide to respond to reports of child abuse. The assessment approach mandates evaluating the alleged abuse, taking needed actions to safeguard the child, and engaging the family in services to enhance family strengths and address identified needs. This approach facilitates the provision of needed services to children and families.)

Recommendation 4 - *to all state agencies and their local units or contractors which conduct activities in the homes of their clients/ customers.* The CDRT recommends that the state agencies require each local unit or contractor, whenever conducting activities in the homes of their clients or customers, to check for the presence and operating status of smoke alarms and the presence of other safety hazards, and to recommend to residents when repairs, changes, or replacements are needed. (This recommendation was also made in the January, 1997 and 1998 and December, 1998 reports.)

Recommendation 5 - *to the Iowa Department of Public Health Bureau of Emergency Medical Services and the Iowa Department of Public Safety.* The CDRT recommends that all emergency response units, law enforcement agencies, and fire departments follow the Infant Death Scene Investigation Protocol, and that the report forms be filled out and submitted as quickly as possible to the proper entity. It is further recommended that information regarding use of this protocol and report form be included in the curriculum of the Iowa Law Enforcement Academy and in all programs in the state that train emergency medical services and fire fighting personnel. (This recommendation was also made in the January, 1997 and 1998 reports.)

Recommendation 6 - *to the Commission of Uniform State Laws.* The CDRT recommends that the Commission of Uniform State Laws propose legislation in this state and promote the passage of legislation in other states which would facilitate the exchange of medical, investigative, or other information pertaining to a child death. Such legislation should include the following language: " A person in possession or control of medical, investigative, or other information pertaining to a child death and child abuse review shall allow the reproduction of the information by the Child Death Review Team of another state operating substantially in conformity with the provisions of this chapter, to be used only in the administration and for the duties of that Child Death Review Team and provided that state grants reciprocal exchange of such child death information to Iowa's Child Death Review Team. Information and records which are otherwise confidential remain confidential under this section. A person does not incur legal liability by reason of releasing information to a Child Death Review Team as required under this section." (This recommendation was also made in the January and December 1998 report.)

Recommendation 7 - *to the Iowa Department of Human Services.* The CDRT recommends that all foster care parents and all licensed in-home daycare providers be required to learn and be certified in child and infant CPR and be required to be recertified in this procedure annually. In addition, foster parents and in-home daycare providers should be required to have extensive education regarding appropriate sleep practices and environment for infants. Their homes should be assessed for secondhand smoke exposure before they are accepted into the foster care program or before they can receive

a license to do in-home childcare. (This recommendation was also made in the December 1998 report.)

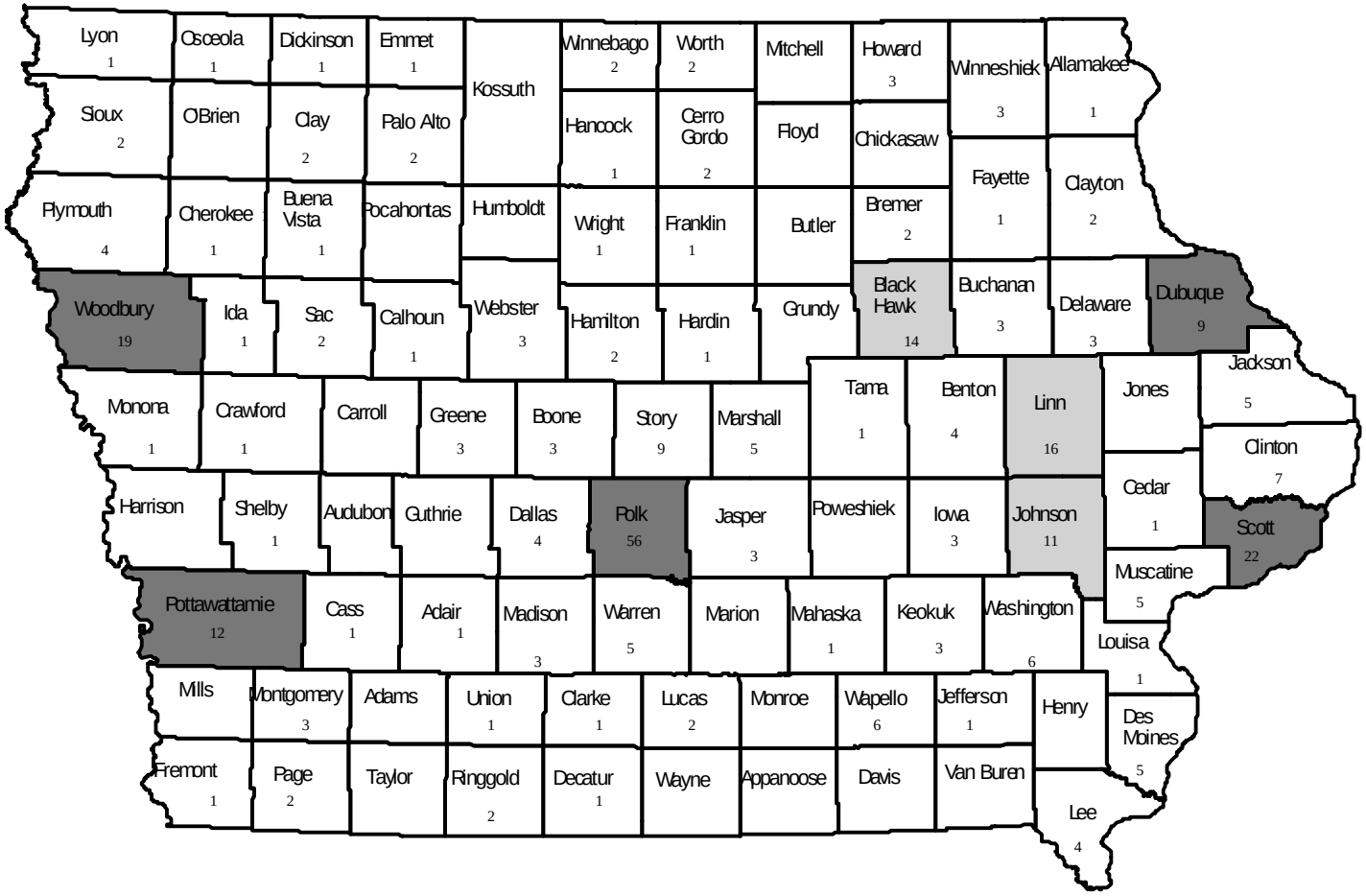
Recommendation 8 – *to the Department of Public Safety*. The CDRT recommends follow up by law enforcement officers of all cases involving potentially life-threatening injuries resulting from any accident for all children through six years of age. In the event that an injured child shall die either in-state or out-of-state from an injury that occurred in their jurisdiction, a thorough investigation of the circumstances surrounding the accident should be conducted by law enforcement personnel.

Recommendation 9 - *to the Iowa Department of Public Health.* The CDRT recommends enhanced educational efforts statewide to parents and other care providers, and to health care professionals who regularly come in contact with new parents and grandparents. This education should focus on all risk factors related to an infant's sleep environment and on issues related to tobacco exposure both in utero and after birth.

Appendix G

1998 Deaths of Children 6 Years of Age And Under By County Of Residence At Time Of Death

The following map shows the county of residence for Iowa children who died.



Child Death Review Team Established
Child Death Review Team Recommended

Out of State children who died in Iowa are as follows:

Illinois: 7 Nebraska: 4 Michigan: 1 Kansas: 1 Wisconsin: 1

IOWA CHILD HEALTH SPECIALTY CLINICS
Parent Consultants by Regional Center

BURLINGTON: 319:752-6313
Mrs. Janelle McGuire
1126 Hagemann Avenue
Burlington, IA 52601
319:754-5776

Mrs. Corinne Menke
806 - 34th Street
Fort Madison, IA 52627
319:372-2895

CARROLL: 712:792-5530
Mrs. Julie Frischmeyer
25585 - 180th Street
Carroll, IA 51401-8611
712:822-5338

COUNCIL BLUFFS: 712:328-6798
Mrs. Terri Lippert
236 Pickardy Lane
Council Bluffs, IA 51503-5007
712:322-5218

Mrs. Nancy A. Larson
604 Maple
Shenandoah, IA 51601
712:246-6452

CRESTON: 515:782-6435
Vacancy

DAVENPORT: 319:421-2141
Vacancy

Mrs. Sharon K. Bower
315 North Tenth Street
Clinton, IA 52732
319:243-6770

DES MOINES: 515:241-8718
Mrs. Paula S. Connolly
1107 W Woodland Park Dr.
West Des Moines, IA 50266
515:223-6714

DUBUQUE: 319:588-0981
Ms. Jeanne Patterson
1649 Hickson Street
Dubuque, IA 52001
319:557-7529

FORT DODGE: 515:955-8326
Ms. Marilyn Walker
609 Walnut Street
Webster City, IA 50595
515:832-2171

Ms. Jenne Stunp
1620 North 23rd Street
Fort Dodge, IA 50501-7914
515:576-7943

MASON CITY: 515:422-7388
Vacancy

OTTUMWA: 515:682-8145
Mrs. Julie Askren
1527 Roland
Chariton, IA 50049
515:774-2198

SIOUX CITY: 712:279-3411
Mrs. Linda Nicolaisen
1721 Pocahontas Avenue
Correctionville, IA 51016
712:372-4325

SPENCER: 712:264-6362
Vacancy

WATERLOO: 319:272-2315
Susan Sivola
27394 Westbrook Street
New Hartford, IA 50660
319:346-2217

CENTRAL OFFICE: 319:356-1035/Bowers
Mrs. Jeanne Stump
201 S. Booth Street
Anamosa, IA 52205-1921
319:462-3450

PCN COORDINATOR
Darrell Bolender
100 Hawkins Drive; Room 239 HS
Iowa City, IA 52242-1011
319:356-8391
c:evelyn\pp\regpcs3 6/21/99

Appendix I

Biographical Sketch

Name (Last, first, middle initial)	Title	Birth Date (Mo. Day Yr)
Lobas, Jeffrey G SS# 286-50-7303	Director, Iowa Child Health Specialty Clinics, Department of Pediatrics University of Iowa	07-06-51

Education (begin with baccalaureate or other initial professional education and include postdoctoral training)

Institution and Location	Degree	Year	Field of Study
Purdue University, West Lafayette, IN	B.S	1972	
The Ohio State University, Columbus, OH	M.P.A.	1974	Public Administration
Medical College of Ohio, Toledo, OH	M.D.	1979	Medical
Theophilius Divinity School; Minneapolis, MN		1993-1996	Non-degree study
University of St. Thomas, St. Paul, MN	Ph.D	2002	Organiz. Development
Medical Training			
University of Oregon, Portland OR	Internship	1979-1980	Pediatrics
Medical College of Ohio,, Toledo, OH	Internship	1980-1981	Internal Medicine
Medical College of Ohio,, Toledo, OH	Residency	1981-1982	Chief Resident
University of Wisconsin, Madison, WI	Fellowship	1983-1986	Pediatric Pulmonary
University of Wisconsin, Madison, WI	Fellowship	1983-1986	Pediatric Critical Care

HONORS

1979 Upjohn Award, Medical Student Achievement Award, Medical College of Ohio
1996 George R. Noren Pediatric Faculty Teaching Award, for 1995-96
1997 Outstanding Faculty Educator Award, Department of Pediatrics, University of Minnesota

MAJOR PROFESSIONAL INTEREST(S)

Pediatric Pulmonology
Pediatric Critical Care
Health Care Service Delivery System Development
Quality Assurance
Care Maps and Critical Pathways

RESEARCH AND PROFESSIONAL EXPERIENCE List in reverse chronological order previous employment and experience. List in reverse chronological order most representative publications.

1997-Present Director, Child Health Specialty Clinics, Iowa City, IA
1995-1997 Chair, Departmental Quality Improvement Program, Hennepin County Medical Center
1994-1997 Director of Pediatric Inpatient Services and of Pediatric Critical Care

	Hennepin County Medical Center, Minneapolis, MN
1988-1992	Managing Business Partner, Children's Respiratory and Critical Care Specialists, PA
	Minneapolis Children's Medical Center, Minneapolis, MN
1974-1976	Health Planner Analyst, Columbus Health Department, Columbus, OH
1973-1974	Administrative Analyst, Columbus Health Department, Columbus, OH

Appendix I

Biographical Sketch

Name (Last, first, middle initial)	Title	Birth Date (Mo. Day Yr)
Schor, Edward L	Medical Director Family & Community Health Division	08/14/44

Education (begin with baccalaureate or other initial professional education and include postdoctoral training)

Institution and Location	Degree	Year	Field of Study
Washington University, St. Louis, Missouri	BA	1966	Psychology
The Chicago Medical School, Chicago, Illinois	MD	1970	Medicine
Baylor Medical School, Houston, Texas		1972	Pediatric Resident
Johns Hopkins Hospital, Baltimore, Maryland		1973	Pediatric Resident
Johns Hopkins School of Public Health, Baltimore, Maryland		1982	Post-doctoral Fellow

HONORS/MEMBERSHIPS

Editorial Board, Journal of Developmental and Behavioral Pediatrics, 1993 - Present
Chairman, Committee on Early Childhood, Adoption and Dependent Care, American Academy of Pediatrics, 1992 - 1996
Editorial Board, Pediatrics, 1996-1999
Editorial Board, Healthy Kids, 1996 - present Chairman, Task Force on the Family, American Academy of Pediatrics, 1997-1999Children's Champion of the Year, Iowa Association for the Education of Young Children, 1998Editorial Board, Journal of Ambulatory Pediatric Association, 1999 - present
Advisory Board, Institute for Social and Behavioral Research, Iowa State University, 1999-present
Marquis Who's Who in Medicine and Healthcare, 1995 - present

MAJOR PROFESSIONAL INTEREST(S)

Maternal & Child Health
Family Functioning & Child Health
Quality of Care

RESEARCH AND PROFESSIONAL EXPERIENCE

List in reverse chronological order previous employment and experience. List in reverse chronological order most representative publications.

1995-Present	Medical Director, Division of Family & Community Health, Iowa Department of Public Health
1990-1995	Director, Functional Outcomes Program, The Health Institute, New England Medical Center
1987-1990	Program Officer, The Henry J. Kaiser Family Foundation
1983-1987	Director, Division of General Pediatrics, University of New Mexico, Department of Pediatrics
1976-1981	Medical Director, Chesapeake Health Plan: HMO, Baltimore, Maryland
1977-1981	Medical Director, Francis X. Gallagher Center for Retarded Citizens
1973-1976	Coordinator, Jr. Year, Health Assoc. Prog., School of Health Services, The Johns Hopkins Univ

Continuation Page For

Biographical Sketch

Name (Last, first, middle initial)	Social Security
Schor, Edward L	300-38-2720

Schor, E., (Ed), Caring for Your School-Age Child: Ages 5 to 12, Bantam Books, 1999

Szilagyi , PG, Schor EL. The Health of Children. Health Services Research, 33(4):1001-1039, 1998

Schor EL. Guiding the family of school-age children. Contemporary Pediatrics 15(3):75-94, 1998

Schor, E.L. Adolescent Alcohol Use: Social Determinants and the Case for Early Family-Centered Prevention. Bulletin of the New York Academy of Medicine, 73(2): 335-356, 1996

Schor, E.L., "Communality and Family-Centered Programs to Improve Children's Health and Well-Being," Bulletin of the New York Medical Society, , 72(2):413-442, 1995

Schor, E. and Menaghan, E., "Family Pathways to Child Health: Social Determinants of Family Functions and Functioning," Levine S., Walsh, D., and Amick, B. (eds), Society and Health, Oxford University Press1995,
pp 18-45

Schor, E., Stidley, C., "Behavioral Implications of Differences Between Children's and Their Parents' Assessment of the Child's Self-Esteem," Journal of Behavioral and Developmental Pediatrics, 16(4): 1-8, 1995

Schor, E., "Health, Health Behavior and Family Research," Hendershot, GE, LeClere, FB (eds), Family Health: From Data to Policy, National Council on Family Relations, Minneapolis, 1993

Schor, E., "Foster Care," Pediatrics in Review, 10(7): 209-216, 1989

Schor, E., "Families, Family Roles and Psychological Diagnoses in Primary Care," Journal of Developmental and Behavioral Pediatrics, 9(6): 327-332, 1988

Schor, E., "Unintentional Injuries: Patterns Within Families," American Journal of Diseases of Children, 141(12): 1280-1284, 1987

Schor, E., Starfield, B., Stidley, C., Hankin, J., "Family Health: Utilization and Effect of Family Membership," MedicalCare, 25(7): 616-626, 1987

Schor, E., "Use of Health Care Services by Children During Presumably Stressful Life Transitions," Pediatrics, 77(6): 834-841, 1986

Biographical Sketch

Borst

Name (Last, first, middle initial)	Title	Birth Date (Mo. Day Yr)
Borst, M. Jane SS# 504-58-9763	Bureau Chief, Family Services Bureau Iowa Department of Public Health	04-11-50

Education (begin with baccalaureate or other initial professional education and include postdoctoral training)

Institution and Location	Degree	Year	Field of Study
Augustana College, Sioux Falls, SD	B.A.	1972	Nursing
University of Iowa, College of Nursing, Iowa City, IA	M.A	1983	Community Health Administration

HONORS/MEMBERSHIPS

Association of Maternal & Child Health Programs,
Region 7 Counselor
Iowa Nurses' Association, District VII
Board of Directors 1987-1990

Sigma Theta Tau, Zeta Chi Chapter
Iowa Public Health Association

MAJOR PROFESSIONAL INTEREST(S)

Family/Community Health
Maternal & Child Health
Nursing Administration
Budgeting for Results

RESEARCH AND PROFESSIONAL EXPERIENCE List in reverse chronological order previous employment and experience. List in reverse chronological order most representative publications.

1993-present	Bureau Chief, Family Services, Iowa Department of Public Health, Des Moines, IA 1999 – present Project Director, Covering Kids, Robert Wood Johnson Foundation 1998 – present Project Director, Title V Abstinence Education Project 1996 – present Title V State MCH Director
1996 – 1999	Program Director, United States Army Reserve, Iowa Practical Nursing Program 95th Division, 10th Battalion, Nursing Brigade, San Antonio, Texas – Des Moines Site
1990-1993	Administrator, Dallas County Public Health Nursing Service 1991-1993 Board of Directors, Iowa State Association of Counties,
1981-1990	Director, Maternal/Child, Iowa Lutheran Hospital, Des Moines, IA 1982 1986 W.K. Kellogg Foundation Demonstration Project, "Defining and Differentiating Nursing Competencies"
1977-1981	Regional Public Health Nursing Supervisor, Iowa Department of Public Health
1976-1977	Public Health Nursing Administrator, Dallas County Public Nursing Service
1974-1976	Staff Public Health Nurse, San Diego County Health Department
1973-1974	Staff Nurse, Medical Surgical Unit, Scripp's Memorial Hospital
1972-1973	Staff Nurse, Obstetrical Units, McKennan Hospital

Appendix I

Biographical Sketch

Name (Last, first, middle initial)	Title	Birth Date (Mo. Day Yr)
Dhooge, Lucia A	Associate Director, Child Health Specialty Clinics	03/10/49

Education (begin with baccalaureate or other initial professional education and include postdoctoral training)

Institution and Location	Degree	Year	Field of Study
University of Iowa	B.S.N	1974	Nursing
Iowa State University	M.B.A	1995	Business Admin.

HONORS/MEMBERSHIPS

Sigma Theta Tau (national honor society for nursing)
Beta Gamma Sigma (honor society for colleges of business)
Vice President, Iowa Association for Home Care (1995)
President, Iowa Hospital Association – Home Care Council (1996)

MAJOR PROFESSIONAL INTEREST(S)

Children with Special Health Care Needs
Self-directed work teams
Team-based performance appraisal
Organizational behavior

RESEARCH AND PROFESSIONAL EXPERIENCE List in reverse chronological order previous employment and experience. List in reverse chronological order most representative publications.

1998-1999 Community Health Consultant, Iowa Department of Public Health
1987-1998 Director, Grinnell Regional Home Care and Public Health
1975-1987 Home Health Nurse/Public Health Nurse, Grinnell Regional Medical Center

CONTRACTS AND MEMORANDA OF AGREEMENT
IOWA DEPARTMENT OF PUBLIC HEALTH

Service Type	Agency/Location	Name of Contract
Child Health - Dental	University of Iowa, Iowa City	Dental Care
	University of Iowa, Iowa City	Sealant Project
	Des Moines Health Center, Des Moines	Sealant Project
	Visiting Nurse Association, Dubuque	Sealant Project
Outreach	Iowa State University Extension, Ames	MCH 1-800 Phone
Staff Development/Education		
	ISU Extension, Ames	Health Leadership Iowa
	ISU Extension, Ames	Comprehensive School Health
Community-based MCH Services		
	Allen Hospital, Waterloo	Maternal Health
	American Home Finding, Ottumwa	Maternal & Child Health
	Jones County Community Hospital, Anamosa	Child Health
	Black Hawk County, Waterloo	Child Health
	Clinton County Board of Health, Clinton	Child Health
	Community Hlth Nrsg of Marion Co., Knoxville	Maternal & Child Health
	Community Health Resources, Muscatine	Maternal & Child Health
	Community Opportunity, Carroll	Maternal & Child Health
	Crawford County, Denison	Maternal & Child Health
	Crittenton Center, Sioux City	Maternal Health
	Des Moines County, Burlington	Maternal & Child Health
	Finley Tri-States Health Group, Inc., Dubuque	Child Health
	Grinnell General Hospital, Grinnell	Maternal & Child Health
	HACAP, Cedar Rapids	Maternal & Child Health
	Hillcrest Family, Dubuque	Maternal Health
	Home Care Iowa, Inc., Iowa City	Home Visiting
	Johnson County, Iowa City	Maternal & Child Health
	Marshalltown Med. & Surgical, Marshalltown	Maternal & Child Health
	Maternal Health Center, Bettendorf	Maternal & Child Health
	MATURA Action, Creston	Maternal & Child Health
	Mid-Iowa Community Action, Marshalltown	Maternal & Child Health
	Mid-Sioux Opportunity, Remsen	Maternal & Child Health
	North Iowa Community Action, Mason City	Maternal & Child Health
	Northeast Iowa MCH, Elkader	Maternal & Child Health
	Siouxland Community Health, Sioux City	Child Health
	Taylor County, Bedford	Maternal & Child Health
	Upper Des Moines, Graettinger	Maternal & Child Health
	VNA Pottawattamie, Council Bluffs	Maternal & Child Health
	Washington County, Washington	Maternal & Child Health
	VNS Polk, Des Moines	Maternal & Child Health
	Webster County, Fort Dodge	Maternal & Child Health
	Women's Health Services, Clinton	Maternal Health

Service Type	Agency/Location	Name of Contract
Infrastructure Building	University of Iowa, Iowa City Hygienic Lab	
	University of Iowa, Iowa City	Birth Defects & Genetic Cons.
	University of Iowa, Iowa City	Muscular Dystrophy
	University of Iowa, Iowa City	Mobile Reg CHC/Home Care
	University of Iowa, Iowa City	Statewide Perinatal Care/ MCH Dietitian
	University of Iowa, Iowa City	Mobile Reg. Spec
	University of Iowa, Iowa City	SSDI
	University of Northern Iowa, Cedar Falls	Barriers to Prenatal Care/ Evaluation of Family Review of Assets
	University of Iowa, Iowa City	MCH Consultant
	University of Iowa, Iowa City	Hearing Screening
	University of Iowa, Iowa City	IUAP, Child Health Consultant
	University of Iowa, Iowa City	Repetitive Prematurity Prevention (OB/GYN)
	University of Iowa, Iowa City	Child & Family Health Needs Assessment
	University of Iowa, Iowa City	EPSDT Newsletter
State Interagency Memoranda	Iowa Department of Education Iowa Department of Human Service - Cooperative Agreement - Outreach Activities - EPSDT Program - Child Care	

CONTRACTS AND MEMORANDA OF AGREEMENT
IOWA CHILD HEALTH SPECIALTY CLINICS

Agency	Name of Contract
Iowa Dept. of Public Health	Cooperative Programmatic Agreement
Iowa Dept. of Education	Supplemental Security Income
Iowa Dept. of Human Services	Early and Periodic Screening, Diagnosis, and Treatment
Iowa Dept. of Human Services	Home & Com.-Based Srvcs, Ill & Handicapped Waiver
Iowa Dept. of Human Services, Iowa Dept. of Education, and Iowa Dept. of Public Health	Early Intervention Services

Report of Dental Sealant Survey for Title V Grant, 2000

In the spring of 2000 the Iowa Department of Public Health conducted a survey to determine the prevalence of dental sealants in third grade children in Iowa. This survey was conducted in order to develop baseline data for measuring progress on increasing the proportion of third grade children with dental sealants in the U.S. The following describes the process for conducting the survey and results obtained.

Human Subjects

The number of children in third grade in Iowa, 36,162, was obtained from the Iowa Department of Education. Each of the 26 child health centers in Iowa was asked to participate in the survey so that no agency would have a large number of children to screen

Examiners and support staff

This survey was conducted in collaboration with statewide child health contract agencies. Both dentist and dental hygienist conducted the screenings. The superintendents and school principals were informed and provided consent forms to be sent home to parents prior to the screenings.

Material and methods

The screenings were visual only and dental probes and mouth mirrors were not used. Toothbrushes were provided to each participating child which were used by the screener to deflect the tongue and cheeks and to cleanse the teeth if necessary. The screening was to determine the number of children with at least one permanent molar with a sealant. In addition, the consent form collected information on source of payment for dental services, whether or not the child was on the free/reduced lunch program, and time since last dental visit.

Data information

All survey forms were sent to the IDPH. Data was entered and analyzed by the use of SPSS. Data collected will be kept confidential. Any report or publication needs permission from the Dental Health Bureau of the IDPH.

Results

1607 out off 2288 (70%) students have been screened. 915 filled in the consent form regarding dental related information. The proportion of children participating to this survey by school ranged from 21% to 94%. Of those surveyed, 38.4% have at least one sealant on their permanent molars. This ranged by county from 19% to 68%. Twenty-five percent of the students were qualified for the free or reduced lunch program.

Forty-one percent of the students have their dental services paid by their family, while 45% have dental insurance. The rest 14% students are Medicaid or HAWKI clients.

Forty-one percent of the students have their dental services paid by their family, while 55% have dental insurance. Fourteen percent of students are Medicaid or HAWK-I clients.

Time since last dental visit is as follows:

	Total	Qualify for Lunch Prgm	Not Qualify For Lunch Prgm	W/out Dental Insurance	Medicaid Or HAWK-I	With Dental Insurance
6 Months	68.8%	51.5%	74.3%	65%	62.7%	73.1%
12 Months	19.8%	28.2%	17.1%	21.8%	22.0%	18.7%
3 Years	8.1%	15%	5.9%	11.5%	11.9%	5.2%
5 Year	1.2%	1%	1.2%	0.9%	1.7%	1.2%
Never	2.2%	4.4%	1.5%	0.9%	1.7%	1.7%
Have Dentist	91.9%	81.4%	95.4%	93.2%	84.2%	97.1%

Discussion

A statewide dental survey in 2000 showed that 41% of Iowa third graders did not have dental insurance, with about 14% paid by Medicaid or HAWK-I. The remaining 45% have dental insurance. In the same age group, more than 10% of them went to the dentist more than three years ago or have never seen a dentist. The dental sealant rate in this age group is 38.9%. Children eligible for the free or reduced lunch program seemed to visit the dentist less frequently than those who were not eligible for the program. About 73% of third graders with dental insurance visited their dentists within 6 months plus another 19% visited their dentist within 12months. The children paid by Medicaid or HAWK-I also tended to visit dentist less frequently than children with dental insurance. This is likely due to less low income children have their own private dentist.

Iowa Department of Public Health and Child Health Specialty Clinics

2000 MATERNAL AND CHILD HEALTH NEEDS ASSESSMENT
April 17, 2000
SURVEY RESULTS

Question 1: The following issues are identified as problems for Iowa's women and children. How important is each for your community?

				Not a problem problem				Serious
	Avg.	**Min.**	**Max.**	**1s**	**2s**	**3s**	**4s**	**5s**
a. Access to primary health care	3.17	1	5	2	18	15	18	7
b. Access to specialty health care	3.2	1	5	2	13	22	17	6
c. Access to preventive health education	3.33	1	5	1	13	19	19	8
d. Access to dental care	4.13	1	5	1	5	9	15	30
e. Access to maternal health care	2.92	1	5	3	20	19	15	3
f. Inadequate food, shelter and clothing	3.23	2	5	0	15	22	17	6
g. Birth to teens	3.9	2	5	0	6	16	15	22
h. Lack of comprehensive health care	3.32	1	5	1	10	23	21	5
i. Lack of community-based health care	3.13	1	5	1	17	20	17	5
j. Lack of family-centered health care	3.35	2	5	0	14	17	23	6
k. Lack of coordination for health care	3.51	2	5	0	11	18	19	11
l. Lack of culturally-competent health care	3.87	2	5	0	9	9	23	19
m. Lack of individual responsibility for personal health and well-being	3.75	2	5	0	9	12	24	15
n. Lack of readiness for parenthood	4.05	2	5	0	1	14	24	19
o. Availability of health insurance to children	3.53	1	5	1	11	19	13	16
p. Availability of health insurance for dental care	4.13	1	5	1	2	13	16	28

q. Availability of continuous health Medicaid insurance to mothers/expecting mothers	3.6	1	5	2	9	15	19	15
r. Availability of health insurance to children with special health care needs	3.47	1	5	2	7	20	21	9
s. Availability of presumptive Medicaid eligibility for pregnant women before they apply for Medicaid	2.67	1	5	7	22	15	9	4
t. Inconsistent identification and follow-up for high-risk and at-risk infants and their families	3.57	1	5	0	10	16	24	10

Question 2: The following are emerging issues of concern. How important is each of these for your community?

				Not a Problem				Serious problem
	Avg.	**Min.**	**Max.**	**1s**	**2s**	**3s**	**4s**	**5s**
a. Lack of abstinence education.	3.22	1	5	6	11	17	16	10
b. Increasing ethnic and cultural diversity of population	4	2	5	0	6	9	24	21
c. Need for home visiting for new parents	3.15	1	5	6	10	21	15	8
d. Quality of health care under managed care	3.64	1	5	2	6	19	16	16
e. Decreasing federal control of public health services	2.96	1	5	2	17	24	9	5
f. Increasing numbers of chemically exposed infants and children.	3.62	1	5	1	7	20	18	24
g. HIV exposed mothers and infants	2.88	1	5	2	23	18	12	4
h. The increase of baby bottle tooth decay	3.39	1	5	2	13	16	16	12
i. Low birth weight/very low birth weight babies	3.18	1	5	2	13	21	20	4
j. Lack of childhood immunizations	2.93	1	5	3	18	22	12	4
k. Care coordination services for children enrolled in managed care programs	3.58	1	5	2	9	17	15	16
l. Care coordination services for special needs children enrolled in managed care programs	3.53	1	5	2	7	19	20	11
m. Accessibility of mental health services for children	3.98	2	5	0	5	12	21	21

n. Accessibility of mental health services for parents	3.95	2	5	0	6	9	27	18
o. Measures of quality for well child care	3.48	2	5	0	12	17	21	10
p. Measures of quality for general pediatric care	3.36	1	5	3	11	17	18	10
q. Resources to serve children with obesity and/or eating disorders	4.07	1	5	0	4	9	26	21
r. Accessibility to a quality/safe childcare environment	3.83	2	51	0	7	12	24	16
s. Transition services for adolescents with special health care needs	3.69	2	5	0	4	21	23	11
t. Insufficient community and/or state data for planning	3.5	1	5	1	12	17	13	15

Question 3: List two additional issues that are health problems in your community.

Dental

- Dentist not accepting Title XIX (2)
- lack of dental access (2)

Substance Abuse

- coordination of services for drug affected infants
- adolescent smoking
- adolescent substance abuse (3)
- increase use of drugs
- alcohol use in elementary schools
- children using tobacco products

Medical Services

- low reimbursement for providers

Insurance

- insurance coverage limits access to pediatric specialists
- the process of obtaining Title XIX is a barrier
- clients lack of follow through with sign up for Title XIX with DHS
- no health insurance for middle aged men and women
- lack of health insurance (2)
- adult women without health insurance who need services beyond family planning

Undocumented/Minority Populations

- language barriers (2)
- transportation for minority populations

Lead Poisoning

- lead poisoning in children (2)
- lack of funds to improve conditions for children with high lead levels

Maternal Health

- smoking during pregnancy
- birth during pregnancy
- prenatal and postnatal depression
- late entry into prenatal care

Other

- lack of home care providers
- lice (3)
- child passenger issues
- women's health care (4)
- follow up of mental health services and family issues
- low income housing
- children behavioral disorders
- STD treatment and testing

- lack of parenting classes
- domestic and child abuse (2)
- lack of family planning education
- lack of environmental ordinance for water and sewer
- referral/access to genetic health care services
- lack of funding for staffing Public Health agencies
- lack of comprehensive health education in schools
- more information on HPV
- lack of acceptable family planning clinics in rural areas
- lack of local opportunities for CEU's for RN regarding community issues
- abstinence training not working

Question 4: The following programs of the Iowa Department of Public Health are meeting the needs of my community.

				Strongly agree				Strongly disagree
	Avg.	**Min.**	**Max.**	**1s**	**2s**	**3s**	**4s**	**5s**
a. Child and Adolescent Health	2.7	1	5	7	18	22	5	5
b. Children with Special Health Care Needs	2.63	1	5	6	22	18	7	3
c. Dental Health	3.66	1	5	3	6	16	16	17
d. Family Planning	2.75	1	5	6	18	21	8	4
e. Maternal Health	2.28	1	4	11	23	21	3	0
f. Public Health Nursing	2.32	1	5	10	25	17	4	1
g. Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	2.12	1	4	17	22	12	6	0
h. Genetic counseling services	2.98	1	5	3	13	24	10	4

Question 5. Comments

- As a MCHWP coordinator, would like to see more networking at this meeting or another meeting during the year
- Funding for increasing maternal health patients needs to increase

- What about complimentary and alternative medicine practices and their impact on PH
- Recent community assessment results made this easy to complete – very useful tool for one county
- We need uniform meconium testing on infants who meet a set of criteria 1) rapid delivery, 2) lack of prenatal care, 3) lots of ER visits
- Complex rules for home health care reimbursement

Number	County #	Region #	County Name	Problem #	Key Word	Priority Statement	Population	Comments
7	3	21	Allamakee	1	Access to Service	Transportation	Community	
8	3	21	Allamakee	2	Access to Service	Health Coverage	Community	
14	4	2	Appanoose	1	Access to Service	Transportation to medical care	Community	
16	4	2	Appanoose	3	Access to Service	Access to care for under/ uninsured	Unspecified	
17	5	5	Audubon	1	Access to Service	Local media not covering events well	Community	
20	5	5	Audubon	4	Access to Service	Limited internet access	Community	
28	7	1	Black Hawk	2	Access to Service	Access to school based health services	Children	
29	7	1	Black Hawk	3	Access to Service	Immigrant and refugee health	Unspecified	
33	7	1	Black Hawk	7	Access to Service	Dual Diagnoisi	Unspecified	
35	7	1	Black Hawk	9	Access to Service	Shortage of nurses	Unspecified	
39	7	1	Black Hawk	13	Access to Service	Uninsured pre-Medicare residence	Unspecified	
45	9	1	Bremer	2	Access to Service	Lack of knowledge of services	Community	
46	10	1	Buchanan	1	Access to Service	Lack of education as to services provided	Community	
65	15	6	Cass	3	Access to Service	Primary and specialty care	Unspecified	
66	16	26	Cedar	1	Access to Service	Transportation for youngest and oldest populations	Community	
67	16	26	Cedar	2	Access to Service	Improved access to service in prenatal period	Pregnant Women	
71	17	18	Cerro Gordo	4	Access to Service	Inadequate integration of services	Community	
78	19	21	Chickasaw	3	Access to Service	Increasing population of nursing home dwellers	Adults	
82	19	21	Chickasaw	7	Access to Service	Increased number of children without health insurance	Children	
90	19	21	Chickasaw	15	Access to Service	Aging physician population and inability to recruit RN's/CHHA's	Community	
91	20	3	Clarke	1	Access to Service	Translators need for increasing Hispanic population	Community	
92	20	3	Clarke	2	Access to Service	Transportation	Community	
96	20	3	Clarke	6	Access to Service	HPSA with 2 retiring physicians	Community	
97	21	20	Clay	1	Access to Service	Education for providers and public on health service delays	Community	
99	21	20	Clay	3	Access to Service	reducing barriers to accessing health care	Community	
100	22	21	Clayton	1	Access to Service	Lack of transportation	Community	
103	23	26	Clinton	1	Access to Service	Limited resources for public health infrastructure	Community	
104	23	26	Clinton	2	Access to Service	Cost of health care with/ without insurance	Community	
106	23	26	Clinton	4	Access to Service	Lack of low-income walk in wellness clinic	Community	
107	23	26	Clinton	5	Access to Service	Lack of primary physicians/ dentists accepting Medicaid	Community	
112	23	26	Clinton	10	Access to Service	Lack of transportation	Community	
113	23	26	Clinton	11	Access to Service	Physician groups dumping difficult or no-pay patients	Community	

115	23	26	Clinton	13	Access to Service	Threat of losing Americorp program	Community	
118	23	26	Clinton	16	Access to Service	Medicare/ Medicaid reimbursement rates below providers costs	Community	
123	24	6	Crawford	2	Access to Service	Under and Uninsured children	Children	
131	25	5	Dallas	2	Access to Service	Need funding for Perry Free Clinic to remain open.	Community	
134	25	5	Dallas	5	Access to Service	Promote alternative housing/ meal alternatives for elderly	Adults	
142	27	2	Decatur	4	Access to Service	Limited resources	Unspecified	
160	33	21	Fayette	1	Access to Service	Transportation for all ages	Community	
161	33	21	Fayette	2	Access to Service	Medical care shortage	Community	
162	33	21	Fayette	3	Access to Service	Language barrier	Community	
167	35	18	Franklin	4	Access to Service	Affordable and accessible healthcare	Community	
168	36	22	Fremont	1	Access to Service	Transportation for elderly	Adults	
170	36	22	Fremont	3	Access to Service	Cost and funding sources	Community	
171	37	5	Green	1	Access to Service	Public health funding	Community	
172	37	5	Green	2	Access to Service	Viability of hospital	Community	
173	37	5	Green	3	Access to Service	Viability HOPES/ enrollment in HAWK-I programs	Children	
182	39	5	Guthrie	2	Access to Service	Lack of coordinated health screenings	Community	
183	39	5	Guthrie	3	Access to Service	Need for education and prevention	Community	
189	39	5	Guthrie	9	Access to Service	68% of residence use out of county hospital	Community	
196	41	18	Hancock	2	Access to Service	Lack of elderly care services	Adults	
212	47	17	Ida	1	Access to Service	Access to treatment providers	Unspecified	
222	49	26	Jackson	1	Access to Service	Lack of insurance for children	Children	
223	49	26	Jackson	2	Access to Service	Lack of transportation	Community	
226	49	26	Jackson	5	Access to Service	Lack of education about existing services	Community	
245	54	2	Keokuk	1	Access to Service	Increased maternal child health services	Pregnant Women	
257	56	8	Lee	5	Access to Service	Lack of education regarding preventive health care	Community	
273	60	17	Lyon	1	Access to Service	Lack of identification system for infants at risk	Parent/ Infant	
280	62	9	Mahaska	1	Access to Service	Problem with Health Care Access	Community	
282	63	3	Marion	1	Access to Service	Elder services	Adults	
287	64	13	Marshall	1	Access to Service	Transpotation for elderly population to medical services	Adults	
289	64	13	Marshall	3	Access to Service	Access to dental care - especially Title XIX	Unspecified	
302	68	2	Monroe	1	Access to Service	Providing assisted living facilities for seniors.	Adults	
309	69	19	Montgomery	4	Access to Service	Lack of resources for the Elderly	Adults	
312	70	4	Muscatine	2	Access to Service	Access to quality health services	Community	
315	71	20	O'Brien	2	Access to Service	Medicare reimbursement for home health care	Unspecified	
320	73	19	Page	1	Access to Service	Language Barriers	Community	
324	73	19	Page	5	Access to Service	Medicaid enhanced services use	Unspecified	
330	75	17	Plymouth	1	Access to Service	Access to care	Community	
339	77	23	Polk	3	Access to Service	Access to medical, dental and mental health care for families and preg. Women	Other	Pregnant women, chidlrena nd adults
340	77	23	Polk	4	Access to Service	Access to comprehensive family planning and reproductive services		
342	78	22	Pottawatta	2	Access to Service	Access to health education	Community	

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357	82	14	Scott	1	Access to Service	Inadequate amount of affordable housing	Community	
358	82	14	Scott	2	Access to Service	Children and families will have access to focused health services	Other	Adults/ Children
359	82	14	Scott	3	Access to Service	Children's health insurance	Children	
360	82	14	Scott	4	Access to Service	Education programs for children's learning	Children	
366	82	14	Scott	10	Access to Service	Juvenile crime	Adolescents	
367	82	14	Scott	11	Access to Service	School system improvement	Children	
380	86	13	Tama	1	Access to Service	Address lack of healthy alternatives for teens	Adolescents	
383	87	19	Taylor	1	Access to Service	Education for preventive health	Community	
384	87	19	Taylor	2	Access to Service	Language Barriers	Unspecified	
392	89	2	Van Buren	2	Access to Service	Low immunization rates	Children	
414	95	18	Winnebago	1	Access to Service	Lack of funding	Community	
415	95	18	Winnebago	2	Access to Service	Lack of local hospital	Community	
417	95	18	Winnebago	4	Access to Service	Health insurance for children and elderly	Other	Adults/ Children
418	95	18	Winnebago	5	Access to Service	High cost of medications	Other	Adults/ Children
420	95	18	Winnebago	7	Access to Service	Limited understanding of services	Unspecified	
422	95	18	Winnebago	9	Access to Service	Lack of transportation	Community	
425	96	21	Winneshiek	1	Access to Service	Lack of cooperation between providers	Community	
432	97	7	Woodbury	3	Access to Service	Access for Medicaid patients and immigrants	Unspecified	
	31	11	Dubuque	2	Access to Service	Coordination of sevices among health providers	Unspecified	
	31	11	Dubuque	4	Access to Service	Translation for Bosnian, Hispanic, and Marshallese	Unspecified	
	31	11	Dubuque	9	Access to Service	Increasing uninsured and underinsured population	Unspecified	
235	51	2	Jefferson	1	Access to Service	Transportation	Unspecified	
	51	2	Jefferson	2	Access to Service	Lack of treatment providers	Unspecified	
	98	18	Worth	5	Access to Service 96	Long term care of elderly	Adults	
108	23	26	Clinton	6	Child Care	Lack of after school, recreational activities for kids	Children	
133	25	5	Dallas	4	Child Care	Child care assistance programs needed	Children	
210	46	25	Humboldt	2	Child Care	Early childhood day care	Children	
217	48	12	Iowa	3	Child Care	Availability of affordable day care	Children	
338	77	23	Polk	2	Child Care	access to basic supplies for care of infancts and children	Children	
343	78	22	Pottawattamie	3	Child Care 6	Lack of funding decreased number of child care facilities	Children	
2	1	15	Adair	2	Chronic Disease	Educate public on access to services	Unspecified	
6	2	19	Adams	3	Chronic Disease	Incidence of Heart Disease	Adults	
10	3	21	Allamakee	4	Chronic Disease	Cardiovascular/ Diabetes	Other	Adults/ Adolescents
25	6	13	Benton	2	Chronic Disease	Cancer awareness	Community	
30	7	1	Black Hawk	4	Chronic Disease	Communinacable diseases in high risk populations	Unspecified	
37	7	1	Black Hawk	11	Chronic Disease	Tuberculosis	Unspecified	
38	7	1	Black	12	Chronic Disease	Immunization rates	Children	

			Hawk					
40	8	16	Boone	1	Chronic Disease	Heart disease and relationship to diet	Adults	
44	9	1	Bremer	1	Chronic Disease	Heart disease, stroke, cerebrovascular disease, skin melanomas and prostate cancer	Adults	
52	11	20	Buena Vista	1	Chronic Disease	Cardiovascular disease mortality is high in county	Adults	
59	13	5	Calhoun	3	Chronic Disease	Chronic disease prevention	Unspecified	
62	14	5	Carroll	3	Chronic Disease	Cardiovascular diseases and diabetes prevention programs	Unspecified	
63	15	6	Cass	1	Chronic Disease	sedentary lifestyle	Unspecified	
72	18	17	Cherokee	1	Chronic Disease	Cardiovascular screening	Adults	
75	18	17	Cherokee	4	Chronic Disease	Breast cancer awareness	Adults	
76	19	21	Chickasaw	1	Chronic Disease	Cardiac disease, obesity, sedentary lifestyle	Adults	
77	19	21	Chickasaw	2	Chronic Disease	Cancer awareness	Unspecified	
86	19	21	Chickasaw	11	Chronic Disease	STD	Unspecified	
125	24	6	Crawford	4	Chronic Disease	Heart disease and Breast cancer	Adults	
130	25	5	Dallas	1	Chronic Disease	Coronary and cerebrovascular disease, diabetes	Unspecified	
144	28	11	Delaware	2	Chronic Disease	Chronic disease in the elderly	Adults	
156	32	20	Emmet	2	Chronic Disease	Premature death due to heart disease	Adults	
157	32	20	Emmet	3	Chronic Disease	Early detection of cancers	Unspecified	
165	35	18	Franklin	2	Chronic Disease	Chronic disease	Unspecified	
174	37	5	Green	4	Chronic Disease	Cerebral Disease	Unspecified	
177	38	1	Grundy	1	Chronic Disease	Cancer - Skin melanoma	Unspecified	
188	39	5	Guthrie	8	Chronic Disease	Lack of funding for chronic disease/ disability residence	Unspecified	
194	40	25	Hamilton	3	Chronic Disease	High incidence of diabetes, maintain quality of life for older adults	Adults	
197	41	18	Hancock	3	Chronic Disease	Chronic disease	Adults	
199	42	13	Hardin	2	Chronic Disease	Cancer, cardiovascular disease, diabetes and asthma	Unspecified	
207	45	21	Howard	5	Chronic Disease	Coronary and chronic disease	Adults	
209	46	25	Humboldt	1	Chronic Disease	Cardiovascular disease	Adults	
219	48	12	Iowa	5	Chronic Disease	Diabetes, heart disease	Adults	
220	48	12	Iowa	6	Chronic Disease	High mortality for prostate, colorectal, uterine and ovarian cancers	Adults	
227	49	26	Jackson	6	Chronic Disease	High rates of chronic diseases	Unspecified	
238	52	12	Johnson	3	Chronic Disease	Heart disease and Stroke	Adults	
240	52	12	Johnson	5	Chronic Disease	Cancer	Unspecified	
248	54	2	Keokuk	3	Chronic Disease	Asthma	Unspecified	
260	57	10	Linn	3	Chronic Disease	Heart Disease	Adults	
261	57	10	Linn	4	Chronic Disease	Cancer	Unspecified	
265	57	10	Linn	8	Chronic Disease	STD's	Unspecified	
266	57	10	Linn	9	Chronic Disease	Diabetes	Unspecified	
284	63	3	Marion	3	Chronic Disease	Cardiovascular disease prevention	Adults	
285	63	3	Marion	4	Chronic Disease	Diabetes	Unspecified	
293	65	22	Mills	4	Chronic Disease	Cardiovascular risk reduction	Adults	
294	66	18	Mitchell	1	Chronic Disease	Cardiovascular disease prevention	Adults	
305	68	2	Monroe	4	Chronic Disease	Coordinating prevention efforts aimed at prevention of chronic diseases	Adults	

310	69	19	Montgomery	5	Chronic Disease	Chronic health problems	Adults	
314	71	20	O'Brien	1	Chronic Disease	Educational programs are needed on obesity or weight reduction and smoking	Unspecified	
317	72	20	Osceola	2	Chronic Disease	Adult education of breast cancer and Cardiovascular health	Adults	
325	73	19	Page	6	Chronic Disease	Cancer death rates and cardiovascular disease	Unspecified	
332	76	20	Pocahontas	1	Chronic Disease	Behavioral risk factors will be evaluated	Unspecified	
346	79	9	Poweshiek	2	Chronic Disease	Colorectal cancer mortality and incidence	Adults	
353	81	5	Sac	1	Chronic Disease	problem lifestyle behaviors predispose citizens to chronic diseases	Unspecified	
361	82	14	Scott	5	Chronic Disease	Coronary heart disease	Adults	
375	85	16	Story	4	Chronic Disease	Prostate cancer	Adults	
390	88	15	Union	4	Chronic Disease	Elderly issues/ Chronic disease	Adults	
391	89	2	Van Buren	1	Chronic Disease	Cardiovascular Disease	Adults	
399	90	2	Wapello	2	Chronic Disease	Cerebrovascular Disease	Unspecified	
400	90	2	Wapello	3	Chronic Disease	Cardio vascular disease	Unspecified	
401	90	2	Wapello	4	Chronic Disease	Sexually Transmitted Diseases	Unspecified	
434	97	7	Woodbury	5	Chronic Disease 61	Lung cancer, heart disease, diabetes	Unspecified	
	31	11	Dubuque	13	Domestic Violence	Domestic abuse and child abuse twice the state rate	Adults/Children	
3	1	15	Adair	3	Domestic Violence	Education programs to reduce domestic violence	Other	Adults/ Children
4	2	19	Adams	1	Domestic Violence	Domestic Abuse	Unspecified	
48	10	1	Buchanan	3	Domestic Violence	Childhood abuse and neglect	Children	
53	11	20	Buena Vista	2	Domestic Violence	Decreasing child abuse	Children	
69	17	18	Cerro Gordo	2	Domestic Violence	Violence and abusive relationships	Other	Children/ Adolescents
81	19	21	Chickasaw	6	Domestic Violence	Child abuse, child safety	Children	
88	19	21	Chickasaw	13	Domestic Violence	Domestic violence, sexual abuse, victim advocate	Unspecified	
128	24	6	Crawford	7	Domestic Violence	Domestic violence and sexual assault	Unspecified	
136	25	5	Dallas	7	Domestic Violence	Increase community awareness and education	Community	
151	30	20	Dickinson	3	Domestic Violence	Child abuse	Children	
187	39	5	Guthrie	7	Domestic Violence	Lack of resources for victims	Unspecified	
208	45	21	Howard	6	Domestic Violence	Decrease domestic abuse	Unspecified	
262	57	10	Linn	5	Domestic Violence	Child abuse	Children	
292	65	22	Mills	3	Domestic Violence	Domestic violence	Unspecified	
297	67	6	Monona	2	Domestic Violence	Domestic violence and child abuse	Other	Adults/ Children
350	80	15	Ringgold	3	Domestic Violence	safe house for domestic violence victims and prevention education	Other	Adults/ Children
378	85	16	Story	7	Domestic Violence	Incidence of domestic violence in ISU community as well as failure to report	Adults	
386	87	19	Taylor	4	Domestic Violence	Statistical information on domestic violence	Unspecified	
388	88	15	Union	2	Domestic Violence	Domestic violence	Unspecified	
404	92	24	Washingto	2	Domestic Violence	Child abuse and neglect, prevention programming	Children	

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410	93	3	Wayne	3	Domestic Violence	Domestic violence and sexual assault	Unspecified	
413	94	25	Webster	3	Domestic Violence	Domestic and child abuse	Other	Adults/ Children
438	97	7	Woodbury	9	Domestic Violence 23	child abuse, sexual assault,	Unspecified	
154	31	11	Dubuque	1	Enviromental	Failing sewage disposal systems and safe water supply	Community	
	31	11	Dubuque	7	Enviromental	Tuberculosis and other communicable disease treatment and follow-up, including foodborne illness and Hepatitis B and TB for foreign-borne	Unspecified	
	31	11	Dubuque	14	Enviromental	Childhood lead poisoning	Children	
	31	11	Dubuque	16	Enviromental	Higher pneumonia death rate than state	Unspecified	
	98	18	Worth	3	Enviromental	Well plugging and rehabilitation/safe water	Community	
	98	18	Worth	4	Enviromental	Childhood lead levels	Children	
12	3	21	Allamakee	6	Environmental	Lead/ Farm Safety	Other	Adults/ Children
19	5	5	Audubon	3	Environmental	Lack of housing development/ rental properties	Community	
22	5	5	Audubon	6	Environmental	Pollution - water/air	Community	
24	6	13	Benton	1	Environmental	Lead screening for children	Children	
31	7	1	Black Hawk	5	Environmental	Childhood lead poisioning	Children	
32	7	1	Black Hawk	6	Environmental	Illegal Dumping	Community	
41	8	16	Boone	2	Environmental	Lead poisoning in children	Children	
43	8	16	Boone	4	Environmental	Antiquated sewer systems	Community	
50	10	1	Buchanan	5	Environmental	Water quality	Community	
57	13	5	Calhoun	1	Environmental	Surface and sub-surface water quality	Community	
70	17	18	Cerro Gordo	3	Environmental	Groundwater issues	Community	
80	19	21	Chickasaw	5	Environmental	Lead screening for children	Children	
85	19	21	Chickasaw	10	Environmental	Smoke detectors, sewage systems	Community	
94	20	3	Clarke	4	Environmental	Air quality concerns	Community	
95	20	3	Clarke	5	Environmental	Water quality and amount	Community	
101	22	21	Clayton	2	Environmental	education needed for radon, Carbon monoxide, substance abuse and poisons	Community	
114	23	26	Clinton	12	Environmental	Access to community buildings for handicapped	Community	
126	24	6	Crawford	5	Environmental	Lead, Radon, Open Sewers, Private wells, Food poisoning prevention	Community	
137	25	5	Dallas	8	Environmental	Lead poisoning in children	Children	
145	28	11	Delaware	3	Environmental	Lead poisoning in children	Children	
175	37	5	Green	5	Environmental	Lead poisoning in children	Children	
206	45	21	Howard	4	Environmental	Increase screening for lead in children	Children	
211	46	25	Humboldt	3	Environmental	Water safety	Community	
215	48	12	Iowa	1	Environmental	High incidence of lead poisoning in children	Children	
221	48	12	Iowa	7	Environmental	Updated septic system	Community	
229	49	26	Jackson	8	Environmental	Need to decrease rates of childhood lead poisoning	Children	
246	54	2	Keokuk	2	Environmental	Water contamination	Community	
247	54	2	Keokuk	2	Environmental	Lead Poisoning	Children	

268	58	4	Louisa	1	Environmental	Elimination of sanitarian position	Community	
272	59	2	Lucas	2	Environmental	Lead	Unspecified	
274	60	17	Lyon	2	Environmental	Lack of poison prevention program	Community	
275	60	17	Lyon	3	Environmental	No sanitarian	Community	
277	61	15	Madison	2	Environmental	Lack fo afordable housing	Community	
279	61	15	Madison	4	Environmental	Rural water quality	Community	
318	72	20	Osceola	3	Environmental	County Sanitarian	Community	
333	76	20	Pocahontas	2	Environmental	Lead Poisoning	Children	
334	76	20	Pocahontas	3	Environmental	Water quality	Community	
344	78	22	Pottawattamie	4	Environmental	Blood Lead level	Children	
345	79	9	Poweshiek	1	Environmental	Elevated blood levels	Children	
354	81	5	Sac	2	Environmental	Environmental contaminants	Community	
355	81	5	Sac	3	Environmental	Lead contaminants in water	Community	
362	82	14	Scott	6	Environmental	Ozone	Community	
376	85	16	Story	5	Environmental	Food borne illnesses	Unspecified	
377	85	16	Story	6	Environmental	Lead testing	Children	
394	89	2	Van Buren	4	Environmental	Lead surveillance	Unspecified	
405	92	24	Washington	3	Environmental	Lead Poisoning	Children	
406	92	24	Washington	4	Environmental	subdivision ordinance for sewer and water system	Community	
429	96	21	Winneshiek	5	Environmental	Examining issues from an epidemiological	Community	
443	99	25	Wright	3	Environmental 54	air, water and lead poisoning	Community	
87	19	21	Chickasaw	12	Injury/ Unintentional	Head injuries, fracture from falls, motor vehicle accidents	Unspecified	
89	19	21	Chickasaw	14	Injury/ Unintentional	Occupational injuries	Unspecified	
127	24	6	Crawford	6	Injury/ Unintentional	Occupational injuries	Unspecified	
179	38	1	Grundy	3	Injury/ Unintentional	Lack of child restarint use	Children	
319	72	20	Osceola	4	Injury/ Unintentional	Farm related	Children	
363	82	14	Scott	7	Injury/ Unintentional	traffic fatalities	Unspecified	
364	82	14	Scott	8	Injury/ Unintentional	Use of safety belts	Unspecified	
395	89	2	Van Buren	5	Injury/ Unintentional	Unintended injury	Unspecified	
407	92	24	Washington	5	Injury/ Unintentional 9	Motor vehicle mortality	Unspecified	
296	67	6	Monona	1	Mental Health	Suicide	Other	Adults/ Adolescents
303	68	2	Monroe	2	Mental Health	Improving mental health services	Unspecified	
308	69	19	Montgomery	3	Mental Health	Stress/ mental health	Unspecified	
389	88	15	Union	3	Mental Health	Mental health and substance abuse	Unspecified	

412	94	25	Webster	2	Mental Health	mental health	Unspecified	
426	96	21	Winneshiek	2	Mental Health	Need for psychiatric care at detox unit	Unspecified	
435	97	7	Woodbury	6	Mental Health	Stability of providers, access and funding challenges	Community	
51	10	1	Buchanan	6	Mental Health	Suicide Rates	Unspecified	
109	23	26	Clinton	7	Mental Health	Lack of funding for mental health	Unspecified	
152	30	20	Dickinson	4	Mental Health	Mental health	Unspecified	
233	50	9	Jasper	4	Mental Health	Suicide attempts in healthy youths	Adolescents	
239	52	12	Johnson	4	Mental Health	Affective psychoses and suicide	Unspecified	
244	53	11	Jones	4	Mental Health	Mental health	Unspecified	
267	57	10	Linn	10	Mental Health 14	Mental health issues	Unspecified	
56	**12**	**18**	**Butler**	**1**	**No Answer**	**No priorities**		
138	26	2	Davis	1	No answers	No response		
163	**34**		**Floyd**	**18**	**No answers**	**No response**		
201	**43**		**Harrison**	**6**	**No Answers**	**No response**		
202	**44**	**24**	**Henry**	**24**	**No Answers**	**No priorities**		
371	**84**	**17**	**Sioux**		**No Answers**	**No priorities**		
402	**91**	**3**	**Warren**		**No Answers**	**No response**		
178	38	1	Grundy	2	Nutrition/ Physical Activity	Unhealthy lifestyles	Unspecified	
301	67	6	Monona	6	Nutrition/ Physical Activity	Unhealthy lifestyle choices	Unspecified	
369	83	6	Shelby	1	Nutrition/ Physical Activity	Reduce obesity in the adult population	Adults	
370	83	6	Shelby	2	Nutrition/ Physical Activity	Baseline height and weight will be obtained from all area schools 1st through 9th.	Children	
428	96	21	Winneshiek	4	Nutrition/ Physical Activity	Obesity and resulting health concerns	Community	
437	97	7	Woodbury	8	Nutrition/ Physical Activity 6	Obesity	Other	Adults/ Children
36	7	1	Black Hawk	10	Oral Health	Shortageof dental services	Unspecified	
153	30	20	Dickinson	5	Oral Health	Oral health	Unspecified	
373	85	16	Story	2	Oral Health	Dental service for Medicaid patients	Unspecified	
403	92	24	Washington	1	Oral Health	access for all ages	Community	
439	97	7	Woodbury	10	Oral Health	Access for Medicaid patients and disabled clients	Unspecified	
	31	11	Dubuque	3	Oral Health 6	Dental access for Title XIX and low income residents	Unspecified	
18	5	5	Audubon	2	Other	Lack of law enforcement officers	Community	
21	5	5	Audubon	5	Other	Part-time employees/ lack of continuity	Adults	
34	7	1	Black Hawk	8	Other	Overrepresentation of African Americans in the health picture	Unspecified	
93	20	3	Clarke	3	Other	Lack of volunteer base	Community	

102	22	21	Clayton	3	Other	Low wages with few/ no benefits	Community	
105	23	26	Clinton	3	Other	Economic Deprivation task force	Community	
110	23	26	Clinton	8	Other	Growing baby boomer generation	Adults	
111	23	26	Clinton	9	Other	Lack of good paying entry level jobs	Adults	
116	23	26	Clinton	14	Other	Feeling among health care providers that industry is involved	Community	
117	23	26	Clinton	15	Other	Threat of loss of firefighters, police due to machine and equipment tax	Community	
119	23	26	Clinton	17	Other	Lack of increased funding for Public Health Nursing and Home Care Aids	Community	
120	23	26	Clinton	18	Other	Lack of evaluation of Public Health Infrastructure and performance standards	Community	
121	23	26	Clinton	19	Other	No Public Health Disaster Plan	Community	
139	27	2	Decatur	1	Other	Local rivalries	Unspecified	
140	27	2	Decatur	2	Other	Attitudes may not be as porogressive as we want	Unspecified	
141	27	2	Decatur	3	Other	Lack of volenteer base in community	Unspecified	
150	30	20	Dickinson	2	Other	Elderly issues	Adults	
166	35	18	Franklin	3	Other	Long term care	Adults	
169	36	22	Fremont	2	Other	Difficulty in motivating community to support classes and programs	Community	
180	38	1	Grundy	4	Other	Lack of school of nursing	Unspecified	
181	39	5	Guthrie	1	Other	Growing elderly population	Adults	
186	39	5	Guthrie	6	Other	48%of families reporting financial difficulties	Community	
198	42	13	Hardin	1	Other	Aging population - elderly care services	Adults	
203	45	21	Howard	1	Other	Elderly will remain safe in their homes and environments	Adults	
232	50	9	Jasper	3	Other	Discrimination with adequate tax resources remedial/ preventive	Unspecified	
250	55	18	Kossuth	1	Other	Fatigue	Unspecified	
251	55	18	Kossuth	2	Other	Resistance to change	Unspecified	
252	55	18	Kossuth	3	Other	Need to become proactive	Unspecified	
254	56	8	Lee	2	Other	Jobs with benefits for families to provide adequate means	Adults	
256	56	8	Lee	4	Other	Maintenance of elderly in their homes	Adults	
276	61	15	Madison	1	Other	High divorce rate	Community	
288	64	13	Marshall	2	Other	Adult day care	Adults	
349	80	15	Ringgold	2	Other	Lack of affordable housing	Unspecified	
372	85	16	Story	1	other	increase aging population	Adults	
397	89	2	Van Buren	7	Other	Senior Health	Adults	
416	95	18	Winnebago	3	Other	Concerns for affordable housing	Community	
419	95	18	Winnebago	6	Other	Increase of minority population	Community	
421	95	18	Winnebago	8	Other	Low paying jobs	Unspecified	
424	95	18	Winnebago	11	Other	Lack of standards	Unspecified	
427	96	21	Winneshiek	3	Other	High poverty rates	Community	
	31	11	Dubuque	5	Other	Sexually transmitted diseases testing and treatment	Unspecified	
	31	11	Dubuque	8	Other 42	Aging population	Adults	
15	4	2	Appanoose	2	Parenting/ Family Support	Parent mentoring and education	Adults	

23	5	5	Audubon	7	Parenting/ Family Support	Low wages	Adults	
61	14	5	Carroll	2	Parenting/ Family Support	Strengthening families	Other	Adults/ Children
185	39	5	Guthrie	5	Parenting/ Family Support	lack of parent support, mentoring and education	Other	Parent/ Children
204	45	21	Howard	2	Parenting/ Family Support	Programs to strengthen families	Other	Parent/ Children
253	56	8	Lee	1	Parenting/ Family Support	Growth of children with early education, child care and family literacy	Children	
307	69	19	Montgomery	2	Parenting/ Family Support	Managing family stress	Adults	
328	74	20	Palo Alto	1	Parenting/ Family Support	Partnering experienced parents with new parents for advice and support	Other	Adults/ Children
1	1	15	Adair	1	Prenatal/ Birth outcomes	Develop program to reduce smoking during pregnancy	Pregnant Women	
68	17	18	Cerro Gordo	1	Prenatal/ Birth Outcomes	Low birth weight, late prenatal care, child abuse	Pregnant Women	
73	18	17	Cherokee	2	Prenatal/ Birth Outcomes	Maintaining Immunizations	Children	
79	19	21	Chickasaw	4	Prenatal/ Birth Outcomes	Low birth weight babies, teen pregnancy	Pregnant Women	
83	19	21	Chickasaw	8	Prenatal/ Birth Outcomes	Children immunized for Hep. B	Children	
124	24	6	Crawford	3	Prenatal/ Birth Outcomes	Low birth weight, late prenatal care, no OB-GYN in county, no early Head Start	Other	Parent/ Children
132	25	5	Dallas	3	Prenatal/ Birth Outcomes	Prenatal classes	Pregnant Women	
143	28	11	Delaware	1	Prenatal/ Birth Outcomes	Lack of support for pregnant teens	Adolescents	
146	29	8	Des Moines	1	Prenatal/ Birth Outcomes	Teen pregnancy	Adolescents	
147	29	8	Des Moines	2	Prenatal/ Birth Outcomes	Low birth weight births	Pregnant Women	
155	32	20	Emmet	1	Prenatal/ Birth Outcomes	Pregnant women delaying prenatal care	Pregnant Women	
184	39	5	Guthrie	4	Prenatal/ Birth Outcomes	lack of special needs, infant care and weekend care	Pregnant Women	
190	39	5	Guthrie	10	Prenatal/ Birth Outcomes	Compliance with recommended immunizations	Children	
192	40	25	Hamilton	1	Prenatal/ Birth Outcomes	Teen pregnancy and access to reproductive health services	Adolescents	
216	48	12	Iowa	2	Prenatal/ Birth Outcomes	High number of prenatal/ fetal deaths/ birth defects	Pregnant Women	

225	49	26	Jackson	4	Prenatal/ Birth Outcomes	Teenage pregnancy	Adolescents	
228	49	26	Jackson	7	Prenatal/ Birth Outcomes	Need to increase rates of childhood immunizations	Children	
234	50	9	Jasper	5	Prenatal/ Birth Outcomes	Late prenatal care and low birth weights due to smoking	Pregnant Women	
259	57	10	Linn	2	Prenatal/ Birth Outcomes	Teen Pregnancy	Adolescents	
264	57	10	Linn	7	Prenatal/ Birth Outcomes	Drug affected outcomes	Pregnant Women	
269	58	4	Louisa	2	Prenatal/ Birth Outcomes	Teen pregnancy	Adolescents	
270	58	4	Louisa	3	Prenatal/ Birth Outcomes	Low birthweight infants	Pregnant Women	
271	59	2	Lucas	1	Prenatal/ Birth Outcomes	Stop smoking in pregnant women, low birth weights	Pregnant Women	
290	65	22	Mills	1	Prenatal/ Birth Outcomes	Low birth weight infants	Pregnant Women	
321	73	19	Page	2	Prenatal/ Birth Outcomes	Low Birth rate	Pregnant Women	
323	73	19	Page	4	Prenatal/ Birth Outcomes	Maternal health smoking	Pregnant Women	
326	73	19	Page	7	Prenatal/ Birth Outcomes	Immunization rates	Children	
327	73	19	Page	8	Prenatal/ Birth Outcomes	Investigation of Infant mortality	Children	
347	79	9	Poweshiek	3	Prenatal/ Birth Outcomes	Maternal health indicators of birth to mother under 20,	Pregnant Women	
348	80	15	Ringgold	1	Prenatal/ Birth Outcomes	Teenage pregnancy and pregnancy prevention education	Adolescents	
374	85	16	Story	3	Prenatal/ Birth Outcomes	Availability of conjugated pneumonia vaccine	Children	
381	86	13	Tama	2	Prenatal/ Birth Outcomes	Women's health issue	Other	Adults/ Adolescents
387	88	15	Union	1	Prenatal/ Birth Outcomes	Maternal Child Health	Pregnant Women	
396	89	2	Van Buren	6	Prenatal/ Birth Outcomes	Maternal and child health	Other	Pregnant Women, Children
408	93	3	Wayne	1	Prenatal/ Birth Outcomes	Teen pregnancy and unplanned pregnancy at anytime	Pregnant Women	
430	97	7	Woodbury	1	Prenatal/ Birth Outcomes	Teenage pregnancy and pregnancy prevention education	Adolescents	
431	97	7	Woodbury	2	Prenatal/ Birth Outcomes	Infant mortality rate	Children	

441	99	25	Wright	1	Prenatal/ Birth Outcomes	Teen pregnancy	Adolescents	
	31	11	Dubuque	6	Prenatal/ Birth outcomes	Child immunization rates	Children	
	31	11	Dubuque	10	Prenatal/ Birth outcomes	Prenatal care issues	Pregnant Women	
	31	11	Dubuque	11	Prenatal/ Birth outcomes	Post-partum issues for families	Unspecified	
	31	11	Dubuque	12	Prenatal/ Birth outcomes	Teen pregnancy	Adolescents	
440	98	18	Worth	1	Prenatal/ Birth Outcomes	Low birth weight	Unspecified	
	98	18	Worth	2	Prenatal/ Birth outcomes 44	Immunization rate at 2 and school entry	Children	
11	3	21	Allamakee	5	Primary and Preventive Care	Immunizations	Children	
54	11	20	Buena Vista	3	Primary and Preventive Care	Increase and maintain immunization rates	Children	
55	11	20	Buena Vista	4	Primary and Preventive Care	Create awareness for women's health issues	Adults	
122	24	6	Crawford	1	Primary and Preventive Care	Rubella and Tuberculosis education	Community	
283	63	3	Marion	2	Primary and Preventive Care	Preventable diseases - influenza and pneumonia	Unspecified	
409	93	3	Wayne	2	Primary and Preventive Care	Sexually transmitted diseases	Other	Adults/ Adolescents
436	97	7	Woodbury	7	Primary and Preventive Care 7	Sexually transmitted diseases	Unspecified	
47	10	1	Buchanan	2	Specialty Care	Lack of education regarding other providers roles	Community	
278	61	15	Madison	3	Specialty Care	Access to specialty care	Community	
423	95	18	Winnebago	10	Specialty Care 3	Lack of specialists	Community	
	31	11	Dubuque	15	Substance Use	Alcohol related arrests twice the state rate	Unspecified	
5	2	19	Adams	2	Substance Use	Incidence of Smoking	Other	Adults/ Adolescents
13	3	21	Allamakee	7	Substance Use	Substance Abuse/ Gambling	Unspecified	
26	6	13	Benton	3	Substance Use	Substance abuse prevention activities	Other	Adults/ Adolescents
42	8	16	Boone	3	Substance Use	Methanphetamine use and production	Community	
49	10	1	Buchanan	4	Substance Use	Substance Abuse	Unspecified	
58	13	5	Calhoun	2	Substance Use	Substance abuse prevention and treatment programs	Unspecified	
60	14	5	Carroll	1	Substance Use	Youth gambling, tobacco use and alcohol consumption	Adolescents	
64	15	6	Cass	2	Substance Use	Substance abuse and addictions	Unspecified	
74	18	17	Cherokee	3	Substance Use	Preteen education on tobacco and alcohol	Adolescents	
84	19	21	Chickasaw	9	Substance Use	Substance abuse teen and adult	Other	Adults/ Adolescents
98	21	20	Clay	2	Substance Use	Addictions to food, alcohol, tobacco, substances and gambling	Unspecified	
129	24	6	Crawford	8	Substance Use	Substance abuse, tobacco use and gambling	Adolescents	
135	25	5	Dallas	6	Substance Use	Substance abuse and addictive behavior prevention	Unspecified	

148	29	8	Des Moines	3	Substance Use	Smoking cessation	Unspecified	
149	30	20	Dickinson	1	Substance Use	Drug and alcohol abuse	Unspecified	
158	32	20	Emmet	4	Substance Use	Tobacco use	Unspecified	
159	32	20	Emmet	5	Substance Use	Alcohol and drug use	Unspecified	
164	35	18	Franklin	1	Substance Use	Substance abuse	Unspecified	
176	37	5	Green	6	Substance Use	Tobacco use in minors	Adolescents	
191	39	5	Guthrie	11	Substance Use	Tobacco ad alcohol use in minors	Adolescents	
193	40	25	Hamilton	2	Substance Use	Substance abuse	Unspecified	
195	41	18	Hancock	1	Substance Use	Substance use	Unspecified	
200	42	13	Hardin	3	Substance Use	Illicit drugs, prescription drugs, alcohol and tobacco use	Unspecified	
205	45	21	Howard	3	Substance Use	Awareness of substance abuse	Unspecified	
213	47	17	Ida	2	Substance Use	Fragmented approach to substance use education	Unspecified	
214	47	17	Ida	3	Substance Use	Lack of community awareness of substance abuse problem	Community	
218	48	12	Iowa	4	Substance Use	Tobacco use for all ages, especially youth	Other	Adults/ Adolescents
224	49	26	Jackson	3	Substance Use	Teenage substance abuse	Adolescents	
230	50	9	Jasper	1	Substance Use	Smoking - low birth weights	Pregnant Women	
231	50	9	Jasper	2	Substance Use	Lack of treatment dollars	Unspecified	
236	52	12	Johnson	1	Substance Use	Alcohol use	Unspecified	
237	52	12	Johnson	2	Substance Use	Tobacco and Marijuana use	Unspecified	
241	53	11	Jones	1	Substance Use	Smoking, chewing tobacco,	Adolescents	
242	53	11	Jones	2	Substance Use	Alcohol use	Adolescents	
249	54	2	Keokuk	4	Substance Use	Tobacco use	Unspecified	
255	56	8	Lee	3	Substance Use	Tobacco prevention	Unspecified	
258	57	10	Linn	1	Substance Use	Alcohol and substance abuse	Unspecified	
263	57	10	Linn	6	Substance Use	Tobacco	Unspecified	
281	62	9	Mahaska	2	Substance Use	Substance abuse and youth	Adolescents	
286	63	3	Marion	5	Substance Use	Tobacco use among youth, pregnant women, and WIC population	Other	Parent/ Children
291	65	22	Mills	2	Substance Use	Tobacco	Unspecified	
295	66	18	Mitchell	2	Substance Use	Tobacco abuse, Alcohol, marijuana	Unspecified	
299	67	6	Monona	4	Substance Use	abuse of alcohol, tobacco	Other	Adults/ Adolescents
300	67	6	Monona	5	Substance Use	Gambling addictions	Unspecified	
304	68	2	Monroe	3	Substance Use	Improving substance abuse services	Unspecified	
306	69	19	Montgomery	1	Substance Use	Alcohol and substance abuse	Unspecified	
313	70	4	Muscatine	3	Substance Use	Availability of drugs, high crime and arrest rates	Unspecified	
316	72	20	Osceola	1	Substance Use	Substance abuse prevention	Unspecified	
329	74	20	Palo Alto	2	Substance Use	Alcohol abuse	Unspecified	
331	75	17	Plymouth	2	Substance Use	Tobacco use	Unspecified	
335	76	20	Pocahonta	4	Substance Use	Efforts will be focused on youth and elderly and their consumption	Other	Adults/

			s					Adolescents
336	76	20	Pocahontas	5	Substance Use	Prevention of youth smoking and purchasing cigarettes illegally	Adolescents	
337	77	23	Polk	1	Substance Use	Substance abuse including tobacco, alcohol, street drugs	Unspecified	
351	80	15	Ringgold	4	Substance Use	Tobacco use	Pregnant Women	
352	80	15	Ringgold	5	Substance Use	Alcohol use	Adolescents	
356	81	5	Sac	4	Substance Use	Substance use among youth	Adolescents	
365	82	14	Scott	9	Substance Use	Alcohol	Unspecified	
368	82	14	Scott	12	Substance Use	Tobacco use	Unspecified	
379	85	16	Story	8	Substance Use	Use of Smoking and methamphetamine	Unspecified	
382	86	13	Tama	3	Substance Use	Collaborating with community partners and new partners to address substance use	Unspecified	
385	87	19	Taylor	3	Substance Use	statistical information on substance use	Unspecified	
393	89	2	Van Buren	3	Substance Use	Substance/ Tobacco use	Unspecified	
398	90	2	Wapello	1	Substance Use	Substance use	Unspecified	
411	94	25	Webster	1	Substance Use	Substance abuse	Unspecified	
433	97	7	Woodbury	4	Substance Use	Alcohol and other drug use	Unspecified	
442	99	25	Wright	2	Substance Use 66	Gambling and tobacco	Unspecified	
9	3	21	Allamakee	3	Unintended Pregnancy	Teen Pregnancy	Adolescents	
27	7	1	Black Hawk	1	Unintended Pregnancy	Teen pregnancy rate	Adolescents	
243	53	11	Jones	3	Unintended pregnancy	Teen Pregnancy	Adolescents	
298	67	6	Monona	3	Unintended Pregnancy	Teen pregnancy	Adolescents	
311	70	4	Muscatine	1	Unintended Pregnancy	Teen pregnancy and its resulting social consequences	Adolescents	
322	73	19	Page	3	Unintended Pregnancy	Teen pregnancy	Adolescents	
341	78	22	Pottawattamie	1	Unintended Pregnancy 7	Funding for adolescent pregnancy prevention programs	Adolescents	

Pool of Problem Areas/Goals for Maternal Health - FSB Staff	Avg Score	Total Score	Disposition
Reduce infant mortality rate to no more than 5 per 1, 000 live births	13.9		F
Increase intended pregnancies for women 14-55 yr	13.5		G
Reduce pregnancies in women ages 12-17	13.5		G
Increase to 90% the proportion women getting prenatal 1st trimester	12.8		H
Increase to 95% the proportion of LBW infants born at high risk delivery facilities	12.7		H
Reduce low birth weight to no more than 5%	12.6		H
Reduce death and illness by preventing STD's	12.6		G
Prevent HIV transmission and associated morbidity and morality	12.2		G
Increase to 72% women on Medicaid getting enhanced services	11.9		H
Percent of children being breastfed at discharge	11.2		H
Increase the number of adults with disabilities providing accessible marketing information	9.2		H
Pool of Problem Areas/Goals for Maternal Health –MCH Advisory Council	**Avg Score**	**Total Score**	**Disposition**
Reduce pregnancies in women ages 12-17	14.5	58	G
Increase to 90% the proportion women getting prenatal 1st trimester	14.0	56	H
Reduce low birth weight to no more than 5%	13.8	55	H
Reduce infant mortality rate to no more than 5 per 1, 000 live births	13.8	55	H
Prevent HIV transmission and associated morbidity and morality	13.0	52	G
Reduce death and illness by preventing STD's	12.5	50	G
Increase to 72% women on Medicaid getting enhanced services	12.3	49	H
Percent of children being breastfed at discharge	11.8	47	H
Increase intended pregnancies for women 14-55 yr	11.3	45	G
Increase to 95% the proportion of LBW infants born at high risk delivery facilities	10.5	42	H
Increase the number of adults with disabilities providing accessible marketing information	8.5	34	G
Pool of Problem Areas/Goals for Maternal Health –Grantee Agencies	**Avg Score**	**Total Score**	**Disposition**
Reduce pregnancies in women ages 12-17	13.0	156	G
Reduce low birth weight to no more than 5%	12.3	146	H
Increase to 90% the proportion women getting prenatal 1st trimester	12.0	144	H
Reduce death and illness by preventing STD's	11.8	141	G
Increase to 95% the proportion of LBW infants born at high risk delivery facilities	11.5	138	H
Reduce infant mortality rate to no more than 5 per 1, 000 live births	11.5	138	H
Increase to 72% women on Medicaid getting enhanced services	11.2	134	H
Increase intended pregnancies for women 14-55 yr	10.9	131	G
Prevent HIV transmission and associated morbidity and morality	10.6	127	G
Percent of children being breastfed at discharge	9.4	113	H
Increase the number of adults with disabilities providing accessible marketing information	8.3	99	G

Pool of Problem Areas/Goals for Child Health –FSB Staff	Avg Score	Total Score	Disposition
Reduce vaccine preventable disease by 50%	13.9	153	H
Increase immunization levels to 90%	13.7	150	H
Increase insurance coverage for children	13.6	149	H
Reduce untreated cavities in children	13.3	146	H
Increase specialty services paid by Medicaid	12.9	142	G
Increase to 70% proportion of children receiving dental care	12.6	138	F
Increase the % of children with a medical home	12.1	133	F
Increase to 94% newborns screened for hearing impairment	12.0	132	H
Reduce child mortality to 21 per 100,00 in ages 1-14	11.9	130	H
Increase to 90% children needing and receiving mental health services under Title V or XIX	11.8	130	F
Increase the % of children receiving licensed or registered child care	11.7	128	G
Increase use of seat belts to 85%	11.4	125	H
Decrease weight gain among children and adolescents	10.6	116	F
Reduce MVA deaths to no more than 15.5 per 100,000	10.2	112	H

Pool of Problem Areas/Goals for Child Health –MCH Advisory Council	Avg Score	Total Score	Disposition
Increase immunization levels to 90%	13.6	68	H
Reduce vaccine preventable disease by 50%	13.2	66	H
Increase specialty services paid by Medicaid	13.2	66	G
Increase insurance coverage for children	13.0	65	H
Increase to 90% children needing and receiving mental health services under Title V or XIX	12.4	62	F
Increase to 70% proportion of children receiving dental care	11.6	58	F
Reduce untreated cavities in children	11.4	57	H
Reduce child mortality to 21 per 100,00 in ages 1-14	11.4	57	H
Increase the % of children with a medical home	11.2	56	F
Increase to 94% newborns screened for hearing impairment	10.0	50	H
Increase the % of children receiving licensed or registered child care	9.6	48	G
Increase use of seat belts to 85%	9.6	48	H
Decrease weight gain among children and adolescents	9.2	46	F
Reduce MVA deaths to no more than 15.5 per 100,000	8.8	44	H

Pool of Problem Areas/Goals for Child Health – Grantee agencies	*Avg Score*	*Total Score*	*Disposition*
Increase insurance coverage for children	13.3	293	H
Increase the % of children with a medical home	13.0	287	F
Reduce untreated cavities in children	12.9	283	F
Increase immunization levels to 90%	12.9	283	H
Increase specialty services paid by Medicaid	12.8	282	G
Reduce vaccine preventable disease by 50%	12.8	281	H
Increase to 70% proportion of children receiving dental care	12.7	280	H
Increase the % of children receiving licensed or registered child care	12.0	264	G
Increase to 90% children needing and receiving mental health services under Title V or XIX	11.6	255	F
Reduce child mortality to 21 per 100,00 in ages 1-14	11.4	251	H
Decrease weight gain among children and adolescents	10.8	237	F
Increase use of seat belts to 85%	10.8	237	H
Reduce MVA deaths to no more than 15.5 per 100,000	10.7	235	H
Increase to 94% newborns screened for hearing impairment	10.5	231	H

Note: The priority levels of CHSC program goals mentioned in the key above were determined as part of the needs assessment activity (CHSC Strategic Direction Assessment Process) described below.

Key:
A – CHSC national performance measure
B – CHSC state performance measure
C – CHSC level 1 priority program goal
D – CHSC level 2 priority program goal
E – CHSC level 3 priority program goal
F – MCH state performance measure
G – Healthy Iowans 2010 goal only
H – MCH national performance measure
1 – Problem was ultimately restated as “Assure quality services for CSHCN in managed care plans”

IOWA MATERNAL & CHILD HEALTH BUDGET 2001

Population Group Served

	TITLE V	MATCH-STATE	MATCH-INCOME	OTHER-Fed/State	TOTAL
MATERNAL HEALTH					
Bureau-Maternal Health	264,990	15,590			280,580
Perinatal Review Team	309,491	61,963			371,454
Prevention-Chem Exposed		41,607			41,607
Barriers Surveillance	25,000	25,000			50,000
Maternal Health-Local	902,670	343,078			1,245,748
Prev Rep Prematurity				19,000	19,000
Deliveries		15,000			15,000
Chlamydia/STD		75,300			75,300
Carryover	328,493				328,493
Maternal Health Subtotal	***1,830,644***	***577,538***		***19,000***	***2,427,182***
INFANT HEALTH					
Infant Mortality Prevention/(U of I)	247,788				247,788
SIDS-Autopsy		9,675			9,675
CDRT		15,000			15,000
IMMP		165,000			165,000
Infant Health SubTotal	**247,788**	**189,675**			**437,463**
CHILD HEALTH					
Immunization		581,208			581,208
Lead		39,547			39,547
Bureau-Child Health*	449,968	4,000			453,968
Bureau-Dental*	231,936				231,936
IUAP-Child Health	60,000				60,000

Outreach(Ext +IUAP+Bureau)	20,000			177,577	197,577
EPSDT				472,688	472,688
Child Health -Local w/ Dental*	1,592,570	1,099,390			2,691,960
Healthy Families -HOPES		622,000			622,000
Acute Care		201,187			201,187
Birth Defects/Genetic Services		643,957			643,957
Parental Notification		33,134			33,134
Carryover	590,104				590,104
Child Health Subtotal	***2,944,578***	***3,224,423***		***650,265***	***6,819,266***
Page 1 of 2					
	TITLE V	MATCH-STATE	MATCH-INCOME	OTHER-Fed/State	TOTAL
CHSC					
CHSC	2,526,097	357,061	401,940	538,815	3,823,913
Neuromuscular		115,613			115,613
Hospital School		1,500,000			1,500,000
CSHC Subtotal	***2,526,097***	***1,972,674***	***401,940***	***538,815***	***5,439,526***
ADMINISTRATION					
Bureau/Support	196,780	39,715			236,495
Audit	45,700				45,700
Adm costs	150,000				150,000
Carryover	60,699				60,699
Subtotal	***453,179***	***39,715***			***492,894***

GRAND TOTAL	**8,002,286**	**6,004,025**	**401,940**	**1,208,080**	**15,616,331**
DPH Subtotal	***5,476,189***	***4,031,351***		***669,265***	***10,176,805***
CSHC Subtotal	***2,526,097***	***1,972,674***	***401,940***	***538,815***	***5,439,526***
FFY01 MCH Budget					
Population Group Served					
Page 2 of 2					

IOWA MATERNAL & CHILD HEALTH BUDGET 2001

Levels of Service

	TITLE V	MATCH-STATE	MATCH-INCOME	OTHER-Fed/State	TOTAL
INFRASTRUCTURE BUILDING					
Bureau-Maternal Health	264,990	15,590			**280,580**
Perinatal Review Team	309,491	61,963			**371,454**
Prevention-Chem Exposed		41,607			**41,607**
Barriers Surveillance	25,000	25,000			**50,000**
Infant Mortality /(U of I)&CDRT	55,200	15,000			**70,200**
Bureau-Child Health*/SF13	449,968	33,134			**483,102**
Bureau - Dental*	231,936				**231,936**
IUAP-Child Health	60,000				**60,000**
EPSDT				472,688	**472,688**
Carryover	918,597				
DPH Subtotal	**2,315,182**	**192,294**		**472,688**	**2,980,164**
CSHC	646,732	36,107			**682,839**
Hospital School		150,000			**150,000**
CHSC Subtotal	**646,732**	**186,107**			**832,839**
Administration	**90,636**	7,943			**98,579**
Infrastructure Subtotal	***3,052,550***	***386,344***		***472,688***	***3,911,582***
POPULATION BASED SERVICES					
Chlamydia/STD		75,300			75,300
Immunization		581,208			581,208

Lead		39,547			39,547
DPH Subtotal		**696,055**			**696,055**
CSHC	200,466				200,466
Hospital School		75,000			75,000
CHSC Subtotal	**200,466**	**75,000**			**275,466**
Administration	**31,723**	**2,780**			**34,503**
Population Based Subtotal	***232,189***	***773,835***			***1,006,024***
ENABLING SERVICES					
Outreach(Ext +IUAP+Bureau)	20,000			177,577	197,577
DPH Subtotal	**20,000**			**177,577**	**197,577**
CSHC	**726,687**	**234,039**		538,815	1,499,541
Hospital School		**75,000**			75,000
CHSC Subtotal	**726,687**	**309,039**		**538,815**	**1,574,541**
Administration	**58,913**	**5,163**			**64,076**
Enabling Services Subtotal	***805,600***	***314,202***		***716,392***	***1,836,194***
Page 1 of 2					
	TITLE V	**MATCH-STATE**	**MATCH-INCOME**	**OTHER-Fed/State**	**TOTAL**
DIRECT HEALTH CARE SERVICES					
Maternal Health-Local	902,670	343,078			1,245,748
Prev Rep Prematurity				19,000	19,000
Deliveries		15,000			15,000
Child Health -Local*	1,785,158	1,103,390			2,888,548
Healthy Families -HOPES/IMMP		787,000			787,000
SIDS-Autopsy		9,675			9,675
Acute Care		201,187			201,187
Birth Defects/Genetic		643,957			643,957

Services					
DPH Subtotal	**2,687,828**	**3,103,287**		**19,000**	**5,810,115**
CSHC	952,212	144,721	401,940		1,498,873
Neuromuscular		57,807			57,807
Hospital School		1,200,000			1,200,000
CSHC Subtotal	**952,212**	**1,402,528**	**401,940**		**2,756,680**
Administration	**271,907**	**23,829**			**295,736**
Direct Services Subtotal	***3,911,947***	***4,529,644***	***401,940***	***19,000***	***8,862,531***
GRAND TOTAL	**8,002,286**	**6,004,025**	**401,940**	**1,208,080**	**15,616,331**
DPH Subtotal (includes admin)	***5,476,189***	***4,031,351***		***669,265***	***10,176,805***
CHSC Subtotal	***2,526,097***	***1,972,674***	***401,940***	***538,815***	***5,439,526***
	8,002,286	6,004,025	401,940	1,208,080	15,616,331
FFY 01 MCH Budget					
Level of Service					0
Page 2 of 2					

IDPH TITLE X FAMILY PLANNING CLINICS IN IOWA

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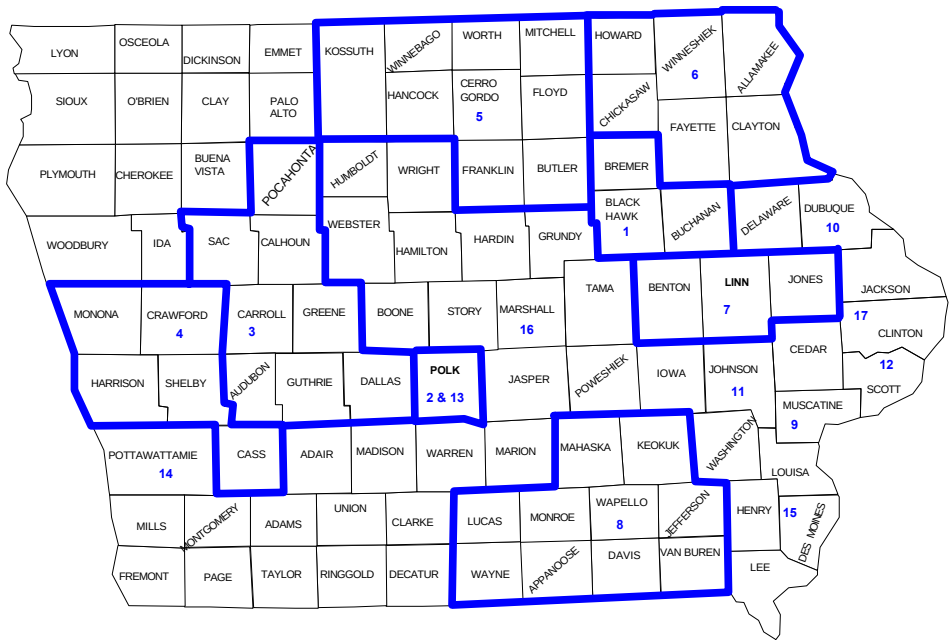

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1. **ALLEN MEMORIAL HOSPITAL**
   Women's Health Center
   233 Vold Drive
   Waterloo, Iowa 50703
   319/235-5090

2. **BROADLAWNS FAMILY PLANNING**
   18th & Hickman Road
   Des Moines, Iowa 50314
   515/282-2340

3. **COMMUNITY OPPORTUNITIES**
   603 W. 8th Street, Box 427
   Carroll, Iowa 51401
   712/792-9266 or 1-800-642-6330

4. **CRAWFORD COUNTY HOME HELATH AND HOSPICE**
   105 N Main St (Courthouse Annex)
   Denison, Iowa 51442
   712/263-3303

5. **NORTH IOWA COMMUNITY ACTION**
   300-15th St, NE, Box 1627
   Mason City, Iowa 50401
   515/426-5044 or 1-800-657-5856

6. **NORTHEAST IOWA COMMUNITY ACTION**
   305 Montgomery St, Box 487
   Decorah, Iowa 52101
   319/382-8436

7. **ST LUKE'S FAMILY HEALTH CENTER**
   855 A Avenue, NE, Lower Level #1
   Cedar Rapids, Iowa 52402
   319/369-7397

8. **ST. LUKE'S FAMILY PLANNING CLINIC, INC**
   228 East Second Street
   Ottumwa, Iowa 52501
   515/382-9955 or 1-800-452-3365

Sponsored by the Family Planning Committee of Iowa

9. **UNITY HEALTH SYSTEM**
   1609 Cedar Street
   Muscatine, Iowa 52791
   319/263-0122

10. **HILLCREST FAMILY SERVICES**
    1005 Asbury Road, Box 1160
    Dubuque, Iowa 52001
    319/583-7357

11. **IOWA CITY FAMILY PLANNING**
    University of Iowa Hospitals
    4137 Westlawn
    Iowa City, Iowa 52242
    319/356-2539

12. **MATERNAL HEALTH CENTER**
    Bettendorf Bank Building, Suite 400, 4th Floor
    852 Middle Road
    Bettendorf, Iowa 50314
    319/359-6633

13. **PLANNED PARENTHOOD OF GREATER IOWA**
    851-19th Street
    Des Moines, Iowa 50314
    515/280-7000

14. **PLANNED PARENTHOOD OF OMAHA/COUNCIL BLUFFS**
    4610 Dodge Street
    Omaha, Nebraska 68132
    402/5541045

15. **PLANNED PARENTHOOD SOUTHEAST IOWA**
    305 North 3rd Street, Suite 403
    Burlington, Iowa 52601
    319/753-2281

16. **WOMEN'S HEALTH & EDUCATION CENTER**
    704 May Street, Box 1146
    Marshalltown, Iowa 50158
    515/752-7159

17. **WOMEN'S HEALTH SERVICES**
    215-6th Avenue, South
    Clinton, Iowa 52732

MCH ADVISORY COUNCIL

Advisory Committee for Perinatal Guidelines

Jeanine Freeman
1001 Grand Avenue
West Des Moines, IA 50265
First Term Expires: 6/03

Iowa Council on Chemically Exposed Infants and Children

American Academy of Pediatrics, Iowa Chapter
Rizwan Shah, MD
Blank Children's Hospital
1212 Pleasant #300
Des Moines, IA 50309
Phone: (515) 241-6000 (office)
(515) 241-8728 (fax)
Term Expires: 6/00
Committee: CSHCN

Birth Defects Advisory Committee
Janet Williams
FACB
First Term Expires: 6/02

Children with Special Health Care Needs Advisory Committee
(vacant)
First Term Expires: 6/01

Iowa State Association of Counties
June Engel
Pocahontas Co. Nursing and Health Nursing Service
99 Court Square
Pocahontas, IA 50574
Phone: (712) 335-4142 (office)
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(712) 335-4300 (Fax)
First Term Expires: 6/02

Iowa Dental Association
Linda Olson-Bieri, DDS
111 West Main
P.O. Box 124
Laurens, IA 50544
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(712) 845-4720 (fax)
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Committee: MCH

Iowa Dietetic Association
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Mid-Iowa Community Action
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Second Term Expires: 6/01
Committee: MCH

American Academy of Family Physicians, Iowa Chapter
(vacant)
First Term Expires:

American College of Obstetricians and Gynecologists, Iowa Chapter
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Committee: MCH

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Patricia L. Pedersen, RN
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Committee: MCH

Parent
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Parent
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Chariton Family Medical Center

1200 North 7th Street
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Phone (515) 774-8103 (office)
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First Term Expires: 12/01
Committee: CSHCN

Parent

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Committee: CSHCN

Parent

Pat Crosley
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First Term Expires: 6/02

Iowa Senate

Patricia Harper
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Term Expires: 6/00
Committee: MCH

Iowa House of Representatives

Bev Nelson-Forbes, Ph.D.
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Third Term Expires: 6/01
Committee: CSHCN

Adolescent Health Provider

Ken L. Cheyne, M.D.
Adolescent Medicine
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First Term Expires: 6/02
Committee: CSHCN

Women's Health

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Family Planning Council of Iowa
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Committee: MCH

Insurance (Private Sector)

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Committee: MCH

Child Care

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Grimes State Office Building
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Term Expires: 6/01

Child Advocate

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Child & Family Policy Center
218 - 6th Avenue, Suite 1021
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First Term Expires: 6/02
Committee: MCH

Social Service
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Infant Mortality Prevention
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First Term Expires: 6/01
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Children's Mental Health
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First Term Expires: 6/02
Committee: MCH

FSB Grantee Committee
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Department of Education, Bureau of Children & Family Services

Department of Human Services, Medical Services Division (Medicaid/HAWK-I)

Department of Human Services, Division of Adult, Children & Family Services

Child Health Specialty Clinics
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Committee: CSHCN

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Mary Weaver
Family & Community Health Division

I. Name

Iowa Maternal and Child Health Advisory Council

II. Mission

To advise the Director of Public Health regarding health and nutrition services for women and Children. To assist the Iowa Department of Public Health in the design and implementation of Maternal and Child Health (MCH) Services, Mobile and Regional Child Health Specialty Clinics (CHSC), and the Special Supplemental Food Program for Women, Infants, and Children (WIC).

III. Functions

To assist in the development of the MCH Grant Application (State Plan) and the WIC State Plan, including the assessment of need, the prioritization of services, and the establishment of objectives. To encourage, in collaboration with other appropriate organizations and groups, public input into the development of the Maternal and Child Health Block Grant Application and the WIC State Plan, and encourage public support of the Maternal and Child Health, Children with Special Health Care Needs and WIC Programs.

To support the development of special projects and conferences regarding health services for women and children.

To advocate for health and nutrition services for women and children.

IV. Membership

Membership shall include representatives of professional groups, agency representatives, legislators (one state senator and one state representative), and individuals with an interest in promoting health services for women and children. Appointments shall be made by the Director of the Department of Public Health and each appointment shall be for a term of three years, commencing on July 1. Appointments shall be gender balanced. No member shall serve more than two full consecutive terms (this provision may be waived by the Director in exceptional cases).

The number of members shall not be fewer than 15 or more than 25.

In order to ensure that one third of the panel rotates each year, staggered terms shall be initiated in June, 1999. For terms expiring during the 1999 calendar year, appointments and reappointments shall be staggered, resulting in a panel with approximately one third of the terms of membership expiring in each of the following years: 2000, 2001, and 2002.

The MCH Advisory Council shall be composed of the following categories:

A. Required Members:
   1) The chair (or designee) of the department's Advisory Committee for Perinatal Guidelines.
   2) The chair (or designee) of the Iowa Council on Chemically Exposed Infants and Children.
   3) The chair (or designee) of the Birth Defects Advisory Committee.
   4) The chair (or designee) of the Children With Special Health Care Needs Advisory Committee.
   5) With approval of the Director of the Iowa Department of Public Health:
      a) A representative chosen by the Iowa State Association of Counties.
      b) A representative chosen by the Iowa Dental Association.
      c) A representative chosen by the Iowa Dietetic Association.
      d) A representative chosen by the American Academy of Family Physicians, Iowa Chapter.
      e) A representative chosen by the American College of Obstetricians and Gynecologists, Iowa Chapter.
      f) A representative chosen by the Iowa Board of Health.
      g) A representative chosen by the American Academy of Pediatrics, Iowa Chapter
   6) Three parent representatives, appointed by the Director of the Iowa Department of Public Health, may represent parents with children with special healthcare needs, parents with children participating in Medicaid or HAWK-I, or parents with children participating in day care or early childhood education.

7) Two legislators (one state senator and one state representative).

B. Discretionary Members. A maximum of 9 additional members may be appointed by the Director of the Iowa Department of Public Health, from among the following:
1) Adolescent health
2) Women's health
3) Insurance (private sector)
4) Child care
5) Legal services
6) Child advocate
7) Social service
8) Infant mortality prevention
9) University extension services
10) Voluntary agency
11) Children's mental health
12) Young person demonstrating leadership abilities

Ex-Officio Members. The following may serve as ex-officio members of the Council:
1) The chair (or designee) of the Family Services Bureau Grantee Committee, Iowa Department of Public Health.
2) A representative of the Department of Education, Bureau of Children & Family Services.
3) A representative of the Department of Human Services, Medical Services Division (Medicaid/ HAWK-I).
4) A representative of the Department of Human Services, Division of Adult, Children & Family Services
5) Director (for designee) of Child Health Specialty Clinics.
6) The chair (or designee) of the Iowa Empowerment Board.

V. Vacancies

Vacancies shall be filled in the same manner in which the original appointments were made. Appointments shall complete the original member's term. The nominations Committee will make recommendations to the Director for appointments.

VI. Meetings

Meetings will be held as necessary and at the call of the Director or the Chair. There shall be a minimum of four meetings per year. At the last scheduled meeting of the fiscal year, the regular meetings for the following year will be scheduled. Notice of meetings will be mailed at least four weeks prior to the meeting date. All meetings will be open to the public.

A majority of the total membership (50% plus one member) shall constitute a quorum.

Action on any issue can only be taken by a majority vote of the entire membership. The Council shall maintain information sufficient to indicate the vote of each member present. If necessary, members may be polled telephonically or electronically.

Subcommittees will meet as necessary.

Attendance shall be expected at all meetings unless circumstances prohibit attendance. Three (3) unexcused absences per fiscal year shall result in termination of membership as determined by the Director or his/her designee.

VII. Officers

The officers shall be the Chair and the Vice-Chair. The Chair will be responsible for conducting Council meetings and representing the Council at appropriate or designated meetings.

The Vice-Chair will be responsible for conducting Council meetings in the absence of the Chair and representing the Council at designated meetings at the request of the Chair.

The Chair and the Vice-Chair shall be elected or re-elected by the members at the last scheduled meeting of the fiscal year. The terms of elected office shall be one year. A member shall not serve as Chair for more than two full consecutive years.

Vacancies in the office of chairperson shall be filled by elevation of the vice-chairperson. Vacancies in the office of vice-chairperson shall be filled by election at the next meeting after the vacancy occurs.

The chairperson shall preside at all meetings of the Council, appoint such subcommittees as deemed necessary, and designate the chairperson of ad hoc subcommittees. If the chairperson is absent or unable to act, the vice-chairperson shall perform the duties of the chairperson. When so acting the vice-chairperson shall have all the powers of and be subject to all restrictions upon the chairperson. The vice-chairperson shall also perform such other duties as may be assigned by the chairperson.

VIII. The Executive Committee

The Executive Committee shall be composed of the Chair and Vice-Chair, assisted by two members appointed by the chair at the beginning of the fiscal year (July 1).

The Executive Committee will meet as necessary to act on behalf of the full Council to develop a recommendation when the council is not in session. The Executive Committee may request staff support and assistance from IDPH management.

IX . Subcommittees

The Council may designate one or more subcommittees to perform such duties as may be deemed necessary. Iowa code defines the Iowa Council on Chemically Exposed Infants and Children as a subcommittee. The chair appoints the Nominations Committee which will submit a slate of potential members and officers.

Additional subcommittees or ad hoc committees may be formed as needed.

(Bylaws revised 9-16-99)